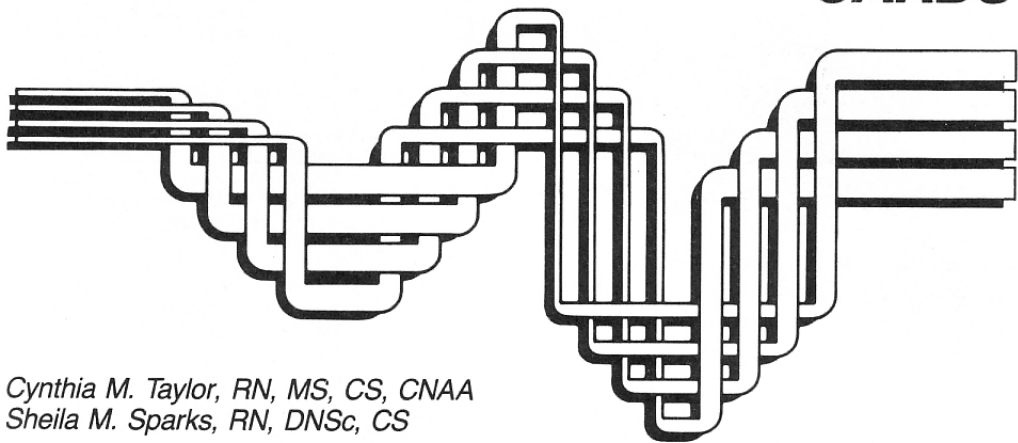


7TH EDITION

The indispensable care-planning guide

Nursing Diagnosis

CARDS™



Cynthia M. Taylor, RN, MS, CS, CNAA
Sheila M. Sparks, RN, DNSc, CS

7th Edition

Nursing Diagnosis Cards™

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The clinical procedures described and recommended in this publication are based on research and consultation with medical and nursing authorities. To the best of our knowledge, these procedures reflect currently accepted clinical practice; nevertheless, they can't be considered absolute and universal recommendations. For individual application, treatment recommendations must be considered in light of the patient's clinical condition and, before administration of new or infrequently used drugs, in light of the latest package-insert information. The authors and the publisher disclaim responsibility for any adverse effects resulting directly or indirectly from the suggested procedures, from any undetected errors, or from the reader's misunderstanding of the text.

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The nursing process offers you a structure for applying your knowledge and skills in an organized, goal-oriented manner. The cornerstone of clinical nursing, the nursing process is a systematic method for:

- determining the patient's problems
- formulating a diagnostic statement
- devising a plan to solve those problems
- implementing the plan or assigning others to implement it
- evaluating the plan's effectiveness.

In its early stages, the nursing process consisted of four distinct but interrelated phases: assessment, planning, implementation, and evaluation. Within the past two decades, diagnosis has emerged as a distinct step in the nursing process. Several events encouraged this important development:

- The American Nurses' Association, in its publication "Standards of Nursing Practice," mentioned nursing diagnosis as a separate and definable act performed by the registered nurse.
- Several states passed nurse practice acts that listed diagnosis as part of the nurse's legal responsibility.
- In 1973, the North American Nursing Diagnosis Association (NANDA) began a formal effort to classify nursing diagnoses. This led to the development of NANDA Taxonomy I Revised—a classification system for

nursing diagnoses based on human response patterns. NANDA continues to meet biennially to review proposed new nursing diagnoses and examine applications of nursing diagnoses in clinical practice, education, and research. Their most recent meeting was held in April, 1992 in San Diego, California. Currently, members of NANDA are working in cooperation with the International Council of Nurses to develop a version of the taxonomy for inclusion in the International Classification of Diseases.

- In 1991, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) incorporated the concept of nursing diagnosis into its revised standards for nursing care. The JCAHO now requires that each patient's care be based on nursing diagnoses that have been made by a registered nurse.

The five phases of the nursing process are dynamic and flexible; they often overlap. The following is a brief summary of each step:

Assessment

This systematic method of collecting data identifies a patient's actual and potential health needs. You may obtain data through a nursing history, a physical examination, and a review of pertinent laboratory and medical information. You should verify assessment findings with the patient whenever possible.

The Nursing Process: An Overview

(continued)

Nursing diagnosis

According to NANDA, the nursing diagnosis is a "clinical judgment about individual, family, or community responses to actual or potential health problems or to life processes. Nursing diagnoses provide the basis for selection of nursing interventions to achieve outcomes for which the nurse is accountable." The nursing diagnosis must be supported by clinical information obtained during patient assessment.

Nursing plan of care

The plan of care refers to a written plan of action designed to help you deliver quality patient care. It includes relevant nursing diagnoses, expected outcomes, and nursing interventions. Expected outcomes describe behaviors or results to be achieved within a specified period of time. You should state expected outcomes in measurable, observable terms and date them. Nursing interventions describe the activities designed to achieve these outcomes. Such activities may include monitoring and providing care to the patient, and educating and supporting the patient, family, or significant other. Expect to individualize each intervention according to the patient's needs.

Also expect to review, revise, and update the entire plan of care on a regular basis, according to institutional policy. Keep in mind that the plan of care usually forms a permanent part of the patient's health re-

cord. Your documentation of goal achievement should be consistent with the contents of the plan of care.

Implementation

Implementation refers to actions taken to achieve expected outcomes, along with subsequent documentation. Remember that any action not documented may be overlooked during quality assurance monitoring or evaluation of care. Another good reason for thorough documentation: It offers a way for you to take rightful credit for your contribution in helping a patient achieve the highest possible level of wellness. After all, nurses use a combination of interpersonal, intellectual, and technical skills when providing care.

Evaluation

The final phase of the nursing process, evaluation refers to the comparison of expected outcomes with results. This phase provides an incentive for reviewing plan of care. Failure to achieve desired outcomes indicates a need to establish new goals and interventions. If health problems are resolved, evaluation provides positive feedback. Evaluation is also conducted through quality-assurance monitoring and other methods for measuring the effectiveness of nursing care.

How to Use *Nursing Diagnosis Cards*

Nursing Diagnosis Cards provide the information you need when caring for patients. Using a simple yet comprehensive style, the authors have developed helpful, practical plans of care based on more than 175 diagnostic statements. For this 7th edition, the authors have revised *Nursing Diagnosis Cards* to provide the most up-to-date information on nursing diagnoses available, including the new diagnoses proposed at the 10th Conference on Classification of Nursing Diagnoses held in April 1992, and approved by a vote of the NANDA membership.

The diagnostic statement appears at the top of each card, followed by an etiologic statement that forms the foundation of the plan of care. In some cases, such as "Health-seeking behaviors," you'll find a series of cards based on differing but related etiologies. Besides providing even more information on the diagnosis, the series serves as an example to help you tailor your own plans of care to individual patients. For nursing students, these cards offer a helpful supplement to your reading in general nursing textbooks.

ORGANIZATION

For every nursing diagnosis and etiologic statement, the front of each card contains the following sections:

Definition

This section appears in the upper left corner of the card. It offers a brief definition of the nursing diagnosis.

Assessment

This section gives guidelines for collecting data to validate the diagnosis. Data may include health history, status, physical findings, behavior; patient statements, and other subjective and objective information.

Defining characteristics

This section lists deviations from normal that help to confirm the diagnosis. For *high-risk* diagnoses—for example, "Skin integrity impairment, high risk for"—this section is labeled "*Risk factors*."

Associated medical diagnoses

In this section, you'll find medical problems that commonly relate to the nursing diagnosis. This list is not exhaustive; by carefully assessing signs and symptoms, you may find additional associated diagnoses.

How to Use *Nursing Diagnosis Cards*

(continued)

The back of each card always contains these three sections:

Expected outcomes

Here you'll find realistic goals for resolving or ameliorating the patient's health problem. They're written in measurable, behavioral terms and cross-referenced to the appropriate nursing interventions.

Interventions and rationales

This section identifies specific activities you can carry out to help achieve expected outcomes for the patient, family, or significant other. This edition of *Nursing Diagnosis Cards* also includes specific rationales for each intervention. The rationales appear in italics to help you locate them easily. Each intervention is numbered to correspond to the appropriate expected outcomes. A double dagger (‡) placed beside a nursing intervention indicates that it usually requires a doctor's order.

Documentation

This section lists critical topics to include in your documentation—for example, patient perceptions, status, response to treatment, and nursing observations and interventions. Keep in mind that your documentation must include evaluations for each expected outcome and any changes made to the plan of care.

In brief, the *Nursing Diagnosis Cards* let you spend more time with your patients and less time on paperwork. That helps you be a better nurse. To help you even more, we've incorporated several valuable features:

- Each diagnostic label has been approved by the North American Nursing Diagnosis Association (NANDA).
- The etiologic statement that accompanies each diagnosis makes diagnostic and care information more clinically relevant. This feature makes it easier to tailor your plan of care to actual patient problems.
- Rationales are provided for nursing interventions.
- The *Nursing Diagnosis Cards* format allows you to insert specific data reflecting your own nursing care practices; for example, instructions about independent, interdependent, or dependent nursing actions, or your own ideas about improving the quality of patient care.

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NANDA Taxonomy I Revised

Human Response Patterns

The North American Nursing Diagnosis Association (NANDA) endorsed its first nursing diagnosis taxonomic structure, NANDA Taxonomy I, in 1986. Taxonomy I Revised 1989, organized around nine human response patterns, is the currently accepted classification system for nursing diagnoses. The nine patterns and their definitions are:

1. Exchanging: mutual giving and receiving
2. Communicating: sending messages
3. Relating: establishing bonds
4. Valuing: assigning worth
5. Choosing: selection of alterations
6. Moving: activity
7. Perceiving: reception of information
8. Knowing: meaning associated with information
9. Feeling: subjective awareness of information

The complete taxonomic structure begins in the next column. Note that Taxonomy II is currently under development.

Pattern 1. Exchanging: A human response pattern involving mutual giving and receiving

- 1.1.2.1 Altered nutrition: More than body requirements
- 1.1.2.2 Altered nutrition: Less than body requirements
- 1.1.2.3 Altered nutrition: High risk for more than body requirements
- 1.2.1.1 High risk for infection
- 1.2.2.1 High risk for altered body temperature
- 1.2.2.2 Hypothermia
- 1.2.2.3 Hyperthermia
- 1.2.2.4 Ineffective thermoregulation
- 1.2.3.1 Dysreflexia
- 1.3.1.1 Constipation
- 1.3.1.1.1 Perceived constipation
- 1.3.1.1.2 Colonic constipation
- 1.3.1.2 Diarrhea
- 1.3.1.3 Bowel incontinence
- 1.3.2 Altered urinary elimination
- 1.3.2.1.1 Stress incontinence
- 1.3.2.1.2 Reflex incontinence
- 1.3.2.1.3 Urge incontinence

(continued)

NANDA Taxonomy I Revised

(continued)

- 1.3.2.1.4 Functional incontinence
- 1.3.2.1.5 Total incontinence
- 1.3.2.2 Urinary retention
- 1.4.1.1 Altered (specify type) tissue perfusion (renal, cerebral, cardiopulmonary, gastrointestinal, peripheral)
 - 1.4.1.2.1 Fluid volume excess
 - 1.4.1.2.2.1 Fluid volume deficit
 - 1.4.1.2.2.2 High risk for fluid volume deficit
- 1.4.2.1 Decreased cardiac output
- 1.5.1.1 Impaired gas exchange
- 1.5.1.2 Ineffective airway clearance
- 1.5.1.3 Ineffective breathing pattern
- 1.5.1.3.1 Inability to sustain spontaneous ventilation
- 1.5.1.3.2 Dysfunctional ventilatory weaning response
- 1.6.1 High risk for injury
 - 1.6.1.1 High risk for suffocation
 - 1.6.1.2 High risk for poisoning
 - 1.6.1.3 High risk for trauma
 - 1.6.1.4 High risk for aspiration
 - 1.6.1.5 High risk for disuse syndrome
- 1.6.2 Altered protection

- 1.6.2.1 Impaired tissue integrity
 - 1.6.2.1.1 Altered oral mucous membrane
 - 1.6.2.1.2.1 Impaired skin integrity
 - 1.6.2.1.2.2 High risk for impaired skin integrity

Pattern 2. Communicating: A human response pattern involving sending messages

- 2.1.1.1 Impaired verbal communication

Pattern 3. Relating: A human response pattern involving establishing bonds

- 3.1.1 Impaired social interaction
- 3.1.2 Social isolation
- 3.2.1 Altered role performance
 - 3.2.1.1.1 Altered parenting
 - 3.2.1.1.2 High risk for altered parenting
 - 3.2.1.2.1 Sexual dysfunction
- 3.2.2 Altered family processes
 - 3.2.2.1 Caregiver role strain
 - 3.2.2.2 High risk for caregiver role strain

(continued)

NANDA Taxonomy I Revised

(continued)

- 3.2.3.1 Parental role conflict
- 3.3 Altered sexuality patterns

Pattern 4. Valuing: A human response pattern involving the assigning of relative worth

- 4.1.1 Spiritual distress (distress of the human spirit)

Pattern 5. Choosing: A human response pattern involving the selection of alternatives

- 5.1.1.1 Ineffective individual coping
- 5.1.1.1.1 Impaired adjustment
- 5.1.1.1.2 Defensive coping
- 5.1.1.1.3 Ineffective denial
- 5.1.2.1 Ineffective family coping: Disabling
- 5.1.2.1.2 Ineffective family coping: Compromised
- 5.1.2.2 Family coping: Potential for growth
- 5.2.1 Ineffective management of therapeutic regimen (individual)
- 5.2.1.1 Noncompliance (specify)
- 5.3.1.1 Decisional conflict (specify)
- 5.4 Health-seeking behaviors (specify)

Pattern 6. Moving: A human response pattern involving activity

- 6.1.1.1. Impaired physical mobility
- 6.1.1.1.1 High risk for peripheral neurovascular dysfunction
- 6.1.1.2 Activity intolerance
- 6.1.1.2.1 Fatigue
- 6.1.1.3 High risk for activity intolerance
- 6.2.1 Sleep pattern disturbance
- 6.3.1.1 Diversional activity deficit
- 6.4.1.1 Impaired home maintenance management
- 6.4.2 Altered health maintenance
- 6.5.1 Feeding self-care deficit
- 6.5.1.1 Impaired swallowing
- 6.5.1.2 Ineffective breastfeeding
- 6.5.1.2.1 Interrupted breastfeeding
- 6.5.1.3 Effective breastfeeding
- 6.5.1.4 Ineffective infant feeding pattern
- 6.5.2 Bathing/hygiene self-care deficit
- 6.5.3 Dressing/grooming self-care deficit
- 6.5.4 Toileting self-care deficit
- 6.6 Altered growth and development
- 6.7 Relocation stress syndrome

(continued)

NANDA Taxonomy I Revised

(continued)

Pattern 7. Perceiving: A human response pattern involving the reception of information

- 7.1.1 Body image disturbance
- 7.1.2 Self-esteem disturbance
 - 7.1.2.1 Chronic low self-esteem
 - 7.1.2.2 Situational low self-esteem
- 7.1.3 Personal identity disturbance
- 7.2 Sensory/perceptual alterations (specify—visual, auditory, kinesthetic, gustatory, tactile, olfactory)
 - 7.2.1.1 Unilateral neglect
- 7.3.1 Hopelessness
- 7.3.2 Powerlessness

Pattern 8. Knowing: A human response pattern involving the meaning associated with information

- 8.1.1 Knowledge deficit (specify)
- 8.3 Altered thought processes

Pattern 9. Feeling: A human response pattern involving the subjective awareness of information

- 9.1.1 Pain
 - 9.1.1.1 Chronic pain
 - 9.2.1.1 Dysfunctional grieving
 - 9.2.1.2 Anticipatory grieving
 - 9.2.2 High risk for violence: Self-directed or directed at others
 - 9.2.2.1 High risk for self-mutilation
 - 9.2.3 Posttrauma response
 - 9.2.3.1 Rape-trauma syndrome
 - 9.2.3.1.1 Rape-trauma syndrome: Compound reaction
 - 9.2.3.1.2 Rape-trauma syndrome: Silent reaction
 - 9.3.1 Anxiety
 - 9.3.2 Fear
-

Activity intolerance

related to imbalance between
oxygen supply and demand

1

Definition

Extreme fatigue or other physical symptoms caused by simple activity

Assessment

- History of circulatory disease, respiratory disease, or both
- Patient's perception of tolerance for activity
- Respiratory status, including arterial blood gases, pulmonary function studies, and respiratory rate, depth, and pattern both at rest and with activity
- Cardiovascular status, including blood pressure, complete blood count, exercise ECG results, and heart rate and rhythm both at rest and with activity
- Knowledge, including understanding of present condition, perception of need to maintain or restore an activity level consistent with capabilities, and physical, mental, and emotional readiness to learn

Defining characteristics

- Verbal report of fatigue or weakness
- Circulatory problems, respiratory problems, or both, including abnormal heart rate or blood pressure in response to activity, arrhythmia or ischemic changes on ECG, and exertional discomfort, dyspnea, tachypnea, or hyperpnea

Associated medical diagnoses (selected)

Acute myocardial infarction, anemias, asthma, bronchitis, chronic obstructive pulmonary disease, congenital cardiac and valvular disorders, congestive heart failure, interstitial lung disease, peripheral vascular disorders, pulmonary edema, pulmonary embolus, respiratory failure, respiratory infections, respiratory neoplasms

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient states desire to increase activity level. (1,2,3,7)
- Patient states understanding of the need to increase activity level gradually. (1,4,5,6,7,9)
- Patient identifies controllable factors that cause fatigue. (5,7,8,9)
- Blood pressure and pulse and respiratory rates remain within prescribed limits during activity. (4,6,7,8,10)
- Patient states sense of satisfaction with each new level of activity attained. (2,3,7,8,9)
- Patient demonstrates skill in conserving energy while carrying out daily activities to tolerance level. (7)
- Patient explains illness and connects symptoms of activity intolerance with deficit in oxygen supply or use. (4,5,7,8,9,10)

Interventions and rationales

1. Discuss with patient the need for activity, *which will improve physical and psychosocial well-being.*
2. Identify activities the patient considers desirable and meaningful *to enhance their positive impact.*

3. Encourage patient to help plan activity progression, being sure to include activities the patient considers essential. *Participation in planning helps ensure patient compliance.*

4. Instruct and help patient to alternate periods of rest and activity *to reduce the body's oxygen demand and prevent fatigue.*

5. Identify and minimize factors that decrease the patient's exercise tolerance *to help increase the activity level.*

6. Monitor physiologic responses to increased activity (including respirations, heart rate and rhythm, blood pressure), *to ensure return to normal a few minutes after exercising.*

7. Teach patient how to conserve energy while performing activities of daily living—for example, sitting in a chair while dressing, wearing lightweight clothing that fastens with Velcro or a few large buttons, and wearing slip-on shoes. *These measures reduce cellular metabolism and oxygen demand.*

8. Teach patient exercises for increasing strength and endurance, *which will improve breathing and gradually increase activity level.*

9. Support and encourage activity to patient's level of tolerance. *This helps develop the pa-*

tient's independence.

10. Before discharge, formulate a plan with the patient and caregivers that will enable the patient either to continue functioning at maximum activity tolerance or to gradually increase the tolerance. For example, teach the patient and caregivers to monitor patient's pulse during activities; to recognize need for oxygen, if prescribed; and to use oxygen equipment properly. *Participation in planning encourages patient satisfaction and compliance.*

Documentation

- Patient's perception of need for activity
- Patient's priorities in performing selected activities
- Patient's description of physical effects of various activities
- Observations made while the patient performs activities
- Skills demonstrated by patient in conserving energy during activity
- New activities patient was able to perform
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

Definition

Extreme fatigue or other physical symptoms caused by simple activity

Assessment

- History of present illness
- Past experience with prolonged bed rest
- Age
- Neurologic status, including level of consciousness, orientation, motor status, and sensory status
- Respiratory status, including arterial blood gases, breath sounds, and the rate, depth, and pattern of respiration both at rest and with activity
- Cardiovascular status, including blood pressure, skin color, hemoglobin and hematocrit, and heart rate and rhythm both at rest and with activity
- Musculoskeletal status, including range of motion and muscle size, strength, and tone

Defining characteristics

- Verbal report of weakness or fatigue
- Circulatory problems, respiratory problems, or both, including exertional discomfort, arrhythmia or ischemic ECG changes, cyanosis, and abnormal heart rate, respiratory rate, or blood pressure
- Inability to move, such as from paralysis (partial or complete) or skeletal traction
- Prolonged bed rest for any reason

Associated medical diagnoses (selected)

Acute respiratory failure, cerebrovascular accident, congestive heart failure, craniocerebral trauma, encephalitis, fractures requiring skeletal traction, Guillain-Barré syndrome, meningitis, multiple sclerosis, peripheral vascular disease, rheumatoid arthritis, spinal cord injury, subacute bacterial endocarditis, vertebral fractures

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient regains and maintains muscle mass and strength. (1,2,3,4)
- Patient maintains maximum joint range of motion. (1,2,3,4)
- Patient performs isometric exercises. (1,4,8)
- Patient helps perform self-care activities. (1,4,6,8)
- Heart rate, rhythm, and blood pressure remain within expected range during periods of activity. (7)
- Patient states understanding of and willingness to cooperate in maximizing activity level. (4,5,6,8)
- Patient performs self-care activities to tolerance level. (4,5,6,7,8)

Interventions and rationales

1. Perform active or passive range-of-motion exercises to all extremities every 2 to 4 hours. *These exercises foster muscle strength and tone, maintain joint mobility, and prevent contractures.*
2. Turn and reposition the patient at least every 2 hours. Establish a turning schedule for the dependent patient. Post schedule at bed-

side and monitor frequency. *Turning and repositioning prevents skin breakdown and improves breathing.*

3. Maintain proper body alignment at all times *to avoid contractures and maintain optimal musculoskeletal balance and physiologic function.*

4. Encourage active exercise:

- a. Provide a trapeze or other assistive device whenever possible. *Such devices simplify moving and turning for many patients, and also allow them to strengthen some upper-body muscles.*
- b. Teach isometric exercises *to allow patient to maintain or increase muscle tone and joint mobility.*
- c. Have patient perform self-care activities. Begin slowly and increase daily, as tolerated. *Activities will help patient regain health.*

5. Provide emotional support and encouragement *to help improve patient's self-concept and motivation to perform activities of daily living.*

6. Involve patient in care-related planning and decision making *to improve compliance.*

7. Monitor physiologic responses to increased activity level, including respirations, heart rate and rhythm, and blood pressure *to ensure they return to normal within a few minutes after exercising.*

8. Teach caregivers to assist patient with self-care activities in a way that maximizes patient's potential. *This enables caregivers to participate in patient's care, and also encourages them to support patient's independence.*

Documentation

- Patient's perceptions about the importance of maintaining optimal levels of activity within restrictions imposed by the illness
- Activities performed by patient
- Observations of physical findings in response to activity
- Teaching activities performed with patient or caregivers
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

Definition

Accentuated risk of extreme fatigue or other physical symptoms following simple activity

Assessment

- History of present illness
- Age
- Past experience with immobility or prescribed bed rest
- Cardiovascular status, including blood pressure, heart rate and rhythm at rest and with activity, complete blood count, skin temperature and color, edema, chest pain or discomfort.
- Respiratory status, including arterial blood gases, auscultation of breath sounds, pain or discomfort associated with respiration, and rate, rhythm, depth, and pattern of respirations at rest and with activity
- Neurologic status, including level of consciousness, orientation, mental status, sensory status, motor status

- Musculoskeletal status, including range of motion, muscle size, strength, tone, and functional mobility as follows:

- 0 = completely independent
- 1 = requires use of equipment or device
- 2 = requires help, supervision, or teaching from another person
- 3 = requires help from another person and equipment or device
- 4 = dependent; does not participate in activity

Risk factors

- Inactivity
- Imposed restriction of movement, including mechanical, medical protocol
- Severe pain
- Prolonged bed rest
- Altered level of consciousness

Associated medical diagnoses (selected)

Cerebrovascular accident, congestive heart failure, fractures (with traction or cast), Guillain-Barré syndrome, multiple sclerosis, severe head injury, spinal cord injury

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient maintains muscle strength and joint range of motion. (1,2,3,4,5,6,7)
- Patient carries out isometric exercise regimen. (4,5,6)
- Patient understands rationale for maintaining activity level and avoids risk factors that may lead to activity intolerance. (11)
- Patient performs self-care activities to tolerance level. (7,8,9,10,12)
- Blood pressure, pulse, and respiratory rate remain within prescribed range during periods of activity (specify). (10)

Interventions and rationales

1. Position patient to maintain proper body alignment. Use assistive devices as needed to maintain joint function and prevent musculo-skeletal deformities.
2. Turn and position the patient at least every 2 hours. Establish turning schedule for dependent patients. Post at bedside and monitor frequency. *Turning helps prevent skin breakdown by relieving pressure.*
3. Assess patient's level of functioning using the functional mobility scale. Communicate

level to all staff. *Communication among staff members assures continuity of care and preserves identified level of independence.*

4. Unless contraindicated, perform range-of-motion exercises every 2 to 4 hours. Progress from passive to active, according to patient tolerance. *Range-of-motion exercises prevent joint contractures and muscular atrophy.*

5. Encourage active movement by helping patient use trapeze or other assistive devices to improve muscle tone and enhance self-esteem.

6. Teach patient how to perform isometric exercises to maintain and improve muscle tone and joint mobility.

7. Assist patient in carrying out self-care activities. Increase patient's participation in self-care, as tolerated to foster independence and improve mobility.

8. Encourage patient involvement in care planning and decision making to enhance compliance.

9. Teach patient, family member, or significant other methods to maximize patient's participation in self-care. *Informed caregivers can encourage patient to become more independent.*

10. Assess patient's physiologic response to increased activity (blood pressure, respirations, heart rate, and rhythm). Teach patient symptoms of over-exertion, such as dizziness, chest pain, and dyspnea. *Monitoring vital signs helps to assess tolerance for increased exertion and activity.*

11. Explain rationale for maintaining or improving activity level. Discuss factors which increase risk of activity intolerance. *Education will help the patient avoid activity intolerance.*

12. Encourage patient to carry out activities of daily living by offering emotional support and positive feedback. *This will enhance patient's self-esteem and motivation.*

Documentation

- Patient's expressions of motivation to maintain maximum activity level within restrictions imposed by illness
- Activities performed by patient
- Teaching instructions provided to patient, family, or significant other
- Patient's physiologic response to increased activity
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

Definition

Inability to modify life-style or behavior consistent with changed health status

Assessment

- Nature of medical diagnosis
- Behavioral responses, including verbal or nonverbal, engagement or disengagement, interest or apathy, acceptance or denial, independence or dependence
- Knowledge of health condition
- Past experiences with family, friends, media
- Psychosocial factors, such as age, sex, ethnic background, religious preference and beliefs, values, occupation, family support, coping style
- Impact of medical diagnosis
- Nutritional status, including modifications in diet, weight changes

Defining characteristics

- Depression over physical changes
- Fear of rejection by staff and family
- Isolation, withdrawal, avoidance
- Poor eating habits
- Refusal to accept health status change
- Refusal to discuss treatment plans
- Refusal to participate in care activities
- Refusal to see visitors
- Somnolence or insomnia
- Unrealistic expectations

Associated medical diagnoses (selected)

Aphasia, cancer, chronic pain, deformity or disfigurement resulting from radical surgery, diabetes mellitus, hemiplegia (or paraplegia or quadriplegia), myocardial infarction, spinal cord injury, terminal illness, ulcerative colitis

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient identifies inability to cope and adjust adequately. (1,2,3,5)
- Patient expresses an understanding of the illness or disease. (1,2,3,4,5,6)
- Patient participates in the health care regimen and plans care activities. (7)
- Patient demonstrates the ability to manage the health problem. (4,6,7)
- Patient shows the ability to accept and adapt to a new health status and integrate learning. (5,8)
- Patient demonstrates new coping strategies. (4,9,10)

Interventions and rationales

1. Encourage the patient to express feelings in a safe, nonthreatening environment. *This allows the patient to define and understand fears, goals, and potential problems.*
2. Allow the patient to grieve. *After working through denial and isolation, anger, bargaining, and depression, the patient will progress toward acceptance.*
3. Provide reassurance that the patient's feelings are normal *to promote coping.*

4. Begin teaching the patient and caregivers the skills needed to adequately manage care *to encourage compliance and adjustment to optimum wellness.*
5. Spend 15 minutes per shift listening to the patient's feelings. *This will help reassure the patient of your interest and concern.*
6. Help the patient identify areas where it's possible to maintain control. *This avoids feelings of powerlessness and lets the patient feel part of a team effort.*
7. Encourage patient to plan care activities, such as time of treatment, personal hygiene, and rest periods, *to help give patient a better sense of control.*
8. Arrange for others who have suffered similar health problems to speak with the patient and family. *This exposes the patient to suitable role models and may allow a trusting, supportive relationship to develop.*
9. Discuss health problems and implications with the family *to enable them to participate in the patient's care and to foster a trusting relationship.*
10. Obtain a consultation with a mental health specialist if the patient develops severe de-

pression or other psychiatric problems. *Although trauma or illness commonly cause some depression, consultation with a mental health professional may help minimize it.*

Documentation

- Patient's nonverbal behaviors
- Patient's verbal expressions of denial, anger, or guilt due to the illness
- Patient's ability or inability to participate in care
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

Definition

Anatomic or physiologic obstruction of the airway that interferes with normal ventilation

Assessment

- History of present illness
- Patient's perception of ability to clear airway
- Knowledge of physical condition
- Neurologic status, including level of consciousness, orientation, sensory status, and motor status
- Respiratory status, including symmetry of chest expansion; use of accessory muscles; cough (productive or nonproductive); respiratory rate, depth, and pattern; such sputum characteristics as color, consistency, amount, odor, and changes from patient's norm; palpation for fremitus; percussion of lung fields; auscultation for breath sounds; arterial blood gases; hemoglobin and hematocrit
- Pulmonary function studies

- Psychosocial status, including interest, motivation, and knowledge

Defining characteristics

- Adventitious breath sounds, such as crackles, rhonchi, stridor, and wheezes
- Anxiety
- Apprehension
- Changes in rate, depth, or pattern of respiration
- Chest wall pain
- Choking or gasping
- Cyanosis
- Dyspnea
- Fever
- Inability to cough
- Ineffective cough
- Nasal flaring
- Noisy respirations
- Patient's report of fatigue and decreased activity tolerance
- Tachypnea

Associated medical diagnoses (selected)

Asthma, cerebrovascular accident, chronic bronchitis, congestive heart failure, emphysema, Guillain-Barré syndrome, interstitial lung disease, multiple sclerosis, myasthenia gravis, pneumonia, systemic lupus erythematosus

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Airway remains patent. (1,2,3,4,5,6,7,8,9,12)
- Adventitious breath sounds lacking. (2,3,4,5)
- Chest X-ray shows no abnormality. (1,2,3,4,5,6,7,8,9,12)
- Oxygen level in normal range. (1,2,3,9,12)
- Patient breathes deeply and coughs to remove secretions. (3,5,6,8)
- Patient expectorates sputum. (3,4,5,6,7)
- Patient demonstrates controlled coughing techniques. (6)
- Ventilation is adequate. (10,11,12)
- Patient shows no signs of pulmonary compromise. (1,2,3,4,5,6,7,8,9,12)
- Patient demonstrates skill in conserving energy while attempting to clear airway. (3,6)
- Patient states understanding of changes needed to diminish oxygen demands. (13)

Interventions and rationales

1. Assess respiratory status at least every 4 hours or according to established standards to detect early signs of compromise.
2. Turn patient every 2 hours. Always position for maximal aeration of lung fields and mobilization of secretions. *This prevents pooling and*

stasis of respiratory secretions.

3. When helping patient cough and deep-breathe, use whatever position best ensures cooperation and minimizes energy expenditure, such as high Fowler's position or sitting on side of bed. *Such positions promote chest expansion and ventilation of basilar lung fields.*
4. Suction, as ordered, to stimulate cough and clear airways. Be alert for progression of airway compromise. *These steps prevent respiratory distress. ‡*
5. Perform postural drainage, percussion, and vibration to facilitate secretion movement. Monitor sputum, noting amount, odor, consistency. *Sputum amount and consistency may indicate hydration status and effectiveness of therapy. Foul-smelling sputum may indicate respiratory infection. ‡*
6. Teach patient an easily performed cough technique to clear airways without fatigue.
7. Encourage sputum expectoration to remove pathogens and prevent spread of infection. Provide tissues and paper bag for hygienic disposal.
8. Give expectorants, bronchodilators, and other drugs, as ordered, and record effective-

ness. Also encourage fluids to help liquefy secretions. *These measures enhance clearance of secretions from airways. ‡*

9. Provide aerosol treatments before chest physiotherapy to optimize results. ‡
10. Administer oxygen, as ordered, to help relieve respiratory distress. ‡
11. Monitor arterial blood gases and hemoglobin to assess oxygenation and ventilatory status; report deviations from baseline levels.
12. If conservative measures fail to maintain PaO₂ within an acceptable range, prepare for endotracheal intubation, as ordered, to maintain artificial airway and optimize PaO₂. ‡
13. Assess patient's learning needs and provide appropriate information to help prevent recurrence of obstruction and promote change in daily activities to reduce oxygen demands.

Documentation

- Patient's perceptions of ability to cough
- Observations of physical findings
- Effectiveness of medications
- Patient's attempts to clear airway
- Maneuvers performed to clear airway
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Airway clearance, ineffective

related to presence of tracheobronchial obstruction or secretions

6

Definition

Anatomic or physiologic obstruction of the airway that interferes with normal ventilation

Assessment

- History of respiratory disorder
- Respiratory status, including rate and depth of respiration; fever; symmetry of chest expansion; use of accessory muscles; cough; sputum (color, consistency, amount, odor, and changes from patient's norm related to infection, irritation, dehydration, exposure to pollutants); palpation for fremitus; percussion of lung fields; auscultation for breath sounds; arterial blood gases; chest X-ray
- Neurologic status, including level of consciousness, orientation, and mental status
- Knowledge, including understanding of physical condition and knowledge and skill in performing maneuvers to clear airway
- Mental, physical, and emotional readiness to learn

Defining characteristics

- Adventitious breath sounds, such as crackles, rhonchi, stridor, wheezes
- Anxiety
- Apprehension
- Changes in rate or depth of respiration
- Choking or gasping
- Cough (productive or nonproductive)
- Cyanosis
- Dyspnea
- Fever
- Nasal flaring
- Noisy respirations
- Tachypnea

Associated medical diagnoses (selected)

Asthma, bronchogenic carcinoma, cerebrovascular accident, chest trauma, chronic bronchitis, chronic obstructive pulmonary disease, Guillain-Barré syndrome, interstitial lung disease, myasthenia gravis, pneumonia, spinal cord injuries, upper airway trauma

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient coughs effectively. (1,3,7,10,11)
- Patient expectorates sputum. (1,3,5,6,7,10,11)
- Adventitious breath sounds absent. (1,4,5,7)
- Chest X-ray reveals no abnormality. (1,4,5,7)
- Patient produces normal sputum. (1,4,5,6)
- Patient drinks 3 to 4 liters of fluid daily. (6)
- Arterial blood gas levels remain at baseline. (1,2,4,5,7,8,9)
- Airway remains patent. (1,2,4,5,7)
- Patient understands and can explain the need for adequate hydration, sputum monitoring, and taking medications as ordered. (12)
- Patient demonstrates controlled coughing techniques. (12)
- Patient performs chest physiotherapy, particularly postural drainage. (12)
- Patient reports symptoms that indicate need for medical intervention. (12)

Interventions and rationales

1. Assess respiratory status at least every 4 hours or according to established standards *to detect early signs of compromise.*
2. Place patient in Fowler's position and sup-

port upper extremities *to aid breathing and chest expansion, and to ventilate basilar lung fields.*

3. Help patient turn, cough, and deep-breathe every 2 to 4 hours *to help prevent pooling of secretions and to maintain airway patency.*

4. Suction as needed *to stimulate cough and clear airways.* Be alert for progression of airway compromise.

5. Provide adequate humidification *to loosen secretions.* ‡

6. Encourage fluids (at least 3,000 ml daily) *to ensure adequate hydration and loosen secretions, unless contraindicated.* ‡

7. Perform postural drainage, percussion, and vibration every 4 hours or as ordered *to enhance mobilization of secretions that interfere with oxygenation.* Monitor sputum *to gauge effectiveness of therapy.* ‡

8. Mobilize patient to full capabilities *to facilitate chest expansion and ventilation.* ‡

9. Avoid supine position for extended periods. Encourage lateral, sitting, prone, and upright positions as much as possible *to enhance lung expansion and ventilation.*

10. Provide tissues and paper bags for hy-

gienic sputum disposal *to prevent spreading infection.*

11. Monitor and document sputum characteristics every shift *to gauge therapy's effectiveness and detect possible respiratory infection.*

12. Teach patient about:

- a. maintaining adequate hydration.
- b. daily monitoring of sputum and reporting changes.
- c. taking prescribed drugs and avoiding over-the-counter respiratory drugs. ‡
- d. controlled coughing and postural drainage.
- e. the need to remain active. *These steps involve patient in own health care.*

Documentation

- Patient's statement of ability to clear airway and comfort in doing so
- Respiratory status, including cough and sputum
- Need for suctioning and its effectiveness
- Effectiveness of medications
- What patient has been taught about airway clearance; response to interventions
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Definition

A decrease in the ability to guard oneself from internal or external threats such as illness or injury

Assessment

- Vital signs
- Health maintenance, including high-risk behaviors, health-promoting activities
- Patient's knowledge of present condition, including diagnosis, treatment, prevention of complications, management of adverse effects
- Coping skills, including physical, psychosocial, and spiritual strengths
- Mobility status
- Comfort level, including symptom management
- Activities of daily living, including rest, sleep, exercise
- Cardiovascular status, including heart rate, rhythm, heart sounds, blood pressure, peripheral pulses, ECG

- Neurologic status, including sensory perception, decision-making abilities, thought processes
- Respiratory status, including gas exchange and breathing patterns
- Nutritional status, including food preferences, modifications in diet, weight changes
- Bowel and bladder elimination patterns
- Protective mechanisms, including immune, hematopoietic, integumentary, and sensorimotor systems
- Laboratory studies, including white blood cell (WBC) count, WBC differential, erythrocyte sedimentation rate, immunoelectrophoresis, enzyme-linked immunosorbent assay (ELISA), and cultures of blood, body fluid, sputum, urine, wounds
- Sexuality patterns

Defining characteristics

- Altered clotting
- Anorexia
- Chills
- Cough
- Deficient immunity
- Diaphoresis
- Disorientation
- Dyspnea
- Fatigue
- Immobility
- Impaired healing
- Insomnia
- Itching
- Maladaptive stress response
- Neurosensory impairment
- Pressure sores
- Restlessness
- Weakness

Associated medical diagnoses (selected)

Acquired immunodeficiency syndrome, alcoholism, anemias, brain tumor, burns, coma, disseminated intravascular coagulation, graft-versus-host disease, hemophilia, idiopathic thrombocytopenia purpura, leukemia, lymphomas, malnutrition, multiple myeloma, multiple sclerosis, neutropenia, pressure sores, rheumatoid arthritis, sickle cell disease

Disorders requiring the following treatments: organ or bone marrow transplant; radiation therapy; surgery or any invasive diagnostic or therapeutic procedure; drug therapy with anti-neoplastics, corticosteroids, immunosuppressants, biological response modifiers, anticoagulants, thrombolytic enzymes, antibiotics

Expected outcomes [†]

- Patient does not experience chills, fever, or other signs and symptoms of illness. (2,3,6)
- Patient demonstrates use of protective measures including conserving energy, maintaining a balanced diet, and obtaining adequate rest. (5)

- Patient demonstrates effective coping skills. (1,7)
- Patient demonstrates personal cleanliness and maintains a clean environment. (2)
- Patient maintains a safe environment. (4)
- Patient demonstrates increased strength and resistance. (5,6,7)
- Immune system response improves. (3,5,6,7)

Interventions and rationales

1. Spend as much time with the patient as possible *to provide comfort and support.*
2. Promote personal and environmental cleanliness *to decrease threat from microorganisms.*
3. Monitor vital signs. *This allows for early detection of complications.*
4. Institute safety precautions *to reduce risk of falls, cuts, or other injuries and subsequent infection, bleeding, and impaired healing.*
5. Teach protective measures including the need to conserve energy, obtain adequate rest, and eat a balanced diet. *Adequate sleep and nutrition enhance immune function. Energy conservation can help to decrease the weakness caused by anemia.*
6. Provide relief for symptoms (fever, chills,

myalgias, weakness). *Discomfort interferes with rest, disturbs nutrition intake, and places added stress on the patient.*

7. Teach patient coping strategies including stress management and relaxation techniques. *Relaxation and decreased stress can increase immune function, thereby improving strength and resistance.*

Documentation

- Patient's understanding of abnormal blood profiles
- Patient's description of measures to prevent or manage complications
- Observations of patient's behavior including health promoting and high-risk activities
- Signs and symptoms of decreased immune resistance in body systems assessed (cardio-pulmonary, neurological, gastrointestinal, genitourinary, integumentary)
- Observations of infection or bleeding
- Interventions to assist with coping strategies and health maintenance and promotion
- Patient's response to interventions
- Evaluations for each expected outcome.

[†] Numbers following outcomes refer to interventions.

Definition

Feeling of threat or danger to self arising from an unidentifiable source

Assessment

- History of panic symptoms (choking feeling in throat, hyperventilation, lightheadedness, dizziness, other physical signs and symptoms of anxiety)
- Psychological status, including patient's explanation of problem, onset, duration, precipitating events, past coping, present coping (note excessive use of repression and denial as major psychological defenses, and note overuse of escape-avoidance behaviors), insight (note patient's understanding of irrationality of fears), motivation to change, anxiety level (+1, +2, +3, +4), secondary gains (from whom and what kinds of secondary gains are being received), current stressors, mental status examination (note escape-avoidance behavior, expression of anxiety in terms

of personal fears, concentration, judgment, affect, impulse control, as well as all other aspects of mental status), personal abilities, talents, strengths

- Sociological status, including support systems, hobbies, interests, work history, family makeup, family roles (evidence of harmony or disharmony), family coping mechanisms, evidence of reinforcement of problem by family, life-style (how this reinforces irrational fears)
- Physiologic status, including medication history (response, effectiveness, side effects)

Defining characteristics

- Agoraphobia
- Behavioral measures to escape or avoid feared event (reclusiveness, avoidance)
- Depersonalization
- Feelings of weakness or failure
- High anxiety when confronting feared situation, object, or activity
- Loss of self-esteem

- Obsessive trends
- Physical symptoms
- Recognition of irrationality of behavior
- Social phobias (such as fear of public speaking, blushing, urinating in public toilet)
- Specific phobias (such as snakes, airplanes, fire)

Associated medical diagnoses (selected)

Anorexia nervosa, anxiety disorder with phobic attacks, schizophrenia

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient experiences reduced anxiety by identifying internal precipitating situations. (1,2,3)
- Patient connects life events to occurrence of anxiety. (1,2,3,4)
- Patient identifies current stressors. (1,2,3,4)
- Patient sets limits and compromises on behavior when ready. (4,5,6,7)
- Patient develops effective coping behaviors. (4,5,6,7,8,9,10)
- Patient maintains autonomy and independence without handicapping fears and use of phobic behavior. (7)

Interventions and rationales

1. Understand own feelings toward patient, *to keep feelings from interfering with treatment.*
2. Accept patient as is. *Forcing the patient to change before he or she is ready causes panic.*
3. Explore factors that precipitate phobic reactions and anxiety. *This is important for understanding patient's dynamics.*
4. Support patient with desensitization techniques. *Encouraging patient to expose self to*

fears helps patient overcome problem.

5. Give patient chance to ventilate feelings. *This reduces patient's tendency to suppress or repress; bottled-up feelings continue to affect behavior even though patient may be unaware of them.*
6. Teach relaxation techniques (such as breathing exercises, progressive muscle relaxation, guided imagery, meditation). *Such measures counteract fight-or-flight response.*
7. Help patient set limits and compromises on behavior when ready. Allow patient to be afraid; *fear is a feeling, neither right nor wrong.*
8. Give patient facts about fear and anxiety and their consequences *to reduce anxiety and encourage patient to help in managing problem.*
9. Encourage patient not to run away when afraid *to help patient learn that fear can be faced and managed.*
10. Help patient develop own techniques for dealing with fears *to establish alternatives to escape or avoidance behaviors.*

Documentation

- Nurse's observation of subjective and objective data
- Interventions to reduce anxiety and increase coping
- Patient's response to interventions
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

Definition

Feeling of threat or danger to self arising from an unidentifiable source

Assessment

- Reason for hospitalization, including patient's perception of problem, onset of current problem, recent stressors, life changes, other precipitants
- Mental status, including orientation to time, place, person; insight regarding current situation; judgment; abstract thinking; general information; mood; affect; recent and remote memory; thought processes; thought content
- Coping, problem-solving ability
- Ability to perform activities of daily living
- Sleep habits
- Dietary and nutritional status
- Available support systems, including family or significant other, friends, clergy, health care agencies

Defining characteristics

- Motor tension, including trembling, twitching, shakiness, muscle tension, aches, soreness, restlessness, easily fatigued
- Autonomic hyperactivity, including shortness of breath or smothering sensation; palpitations or tachycardia; sweating; cold, clammy hands; dry mouth; dizziness; lightheadedness; nausea, diarrhea; other abdominal distress; flushes (hot flashes) or chills; frequent urination; difficulty swallowing
- Vigilance and scanning (feeling keyed-up or on edge; exaggerated startle response; difficulty concentrating; insomnia; irritability)

Associated medical diagnoses (selected)

Any hospitalized patient can experience anxiety. It appears most often in patients with conditions requiring surgery, diseases that pose a threat to self-concept, diseases that require use of high-technology devices or techniques, or those who have newly diagnosed chronic or terminal diseases. High levels of anxiety can result from a situational crisis so devastating that it requires hospitalization.

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient identifies factors that elicit anxious behaviors. (5,6)
- Patient discusses activities that tend to decrease anxious behaviors. (1,5,6)
- Patient practices progressive relaxation techniques _____ times a day. (11)
- Patient copes with current medical situation (specify) without demonstrating severe signs of anxiety (specify for individual). (1,2,3,4,5,6,7,8,9,10,11,12)

Interventions and rationales

1. Spend 10 minutes with patient twice a shift. Convey a willingness to listen. Offer verbal reassurance; for example, "I know you're frightened. I'll stay with you." *Specific amount of uninterrupted, non-care-related time spent with anxious patient builds trust and reduces tension. Active listening helps patient ventilate feelings.*
2. Give patient clear, concise explanations of anything about to occur. Avoid information overload, since the anxious patient cannot assimilate many details. *Anxiety may impair patient's cognitive abilities.*

3. Listen attentively; allow patient to express feelings verbally. *This may allow patient to identify anxious behaviors and discover the source of anxiety.*
4. Make no demands on patient. *Anxious patient may respond to excessive demands with hostility and abuse.*
5. Identify and reduce as many environmental stressors as possible. This may apply to people as well as other stimuli. *Anxiety often results from lack of trust in the environment.*
6. Have patient state what kinds of activities promote feelings of comfort, and encourage patient to perform them (specify). *This gives patient a sense of control.*
7. Remain with patient during severe anxiety. *Anxiety is often related to fear of being left alone.*
8. Include patient in decisions related to care when feasible. *Anxious patient may mistrust own abilities; involvement in decision making may reduce anxious behaviors.*
9. Support family or significant other in coping with patient's anxious behavior. *Involving family or significant other in process of reassurance and explanation allays patient's anxiety*

as well as their own.

10. Allow extra visiting periods with family if this seems to allay patient's anxiety. *This allows anxious patient and family to support each other according to their abilities and at their own pace.*
11. Teach patient relaxation techniques to be performed at least every 4 hours, such as guided imagery, progressive muscle relaxation, meditation. *These measures can restore psychological and physical equilibrium by decreasing autonomic response to anxiety.*
12. Refer patient to community or professional mental health resources, *to provide ongoing mental health assistance.*

Documentation

- Patient's statement of anxiety and feelings of relief
- Statements about observable signs of patient's anxiety
- Interventions to reduce patient's anxiety
- Effectiveness of nursing interventions that can be observed
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

Definition

Feeling of threat or danger to self arising from an unidentifiable source

Assessment

- History of possible stress-related symptoms, including chest pain, rapid pulse, palpitations, hyperventilation, sighing, nausea, constipation, diarrhea, anorexia, compulsive eating, sweating, hives, or rashes
- Anxiety-related behaviors, including nail biting, sleep disturbances, finger tapping, foot swinging, voice quivering, and cheek biting
- Current worries, fears, concerns
- Recent life changes
- Usual coping methods
- Mood
- Personality

Defining characteristics

- Apprehension
- Distress

- Existing problem that poses an immediate threat of death
- Extraneous movements
- Facial tension
- Fearfulness
- Feelings of inadequacy
- Focus on self
- Glancing about
- Increased helplessness
- Increased perspiration
- Increased tension
- Increased urinary frequency
- Increased wariness
- Insomnia
- Overexcitedness
- Poor eye contact
- Regretfulness
- Restlessness
- Shakiness
- Sympathetic stimulation, such as cardiovascular excitation, superficial vasoconstriction, and pupil dilation

- Trembling (hand tremors)
- Uncertainty

Associated medical diagnoses (selected)

Acute myocardial infarction, acute respiratory failure, Adams-Stokes syndrome, adult respiratory distress syndrome, malignant neoplasms, multisystem trauma, post-cardiac arrest, shock (cardiogenic, anaphylactic, hemorrhagic)

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient states feelings of anxiety. (1,2,3)
- Patient identifies cause of anxiety. (4,5)
- Patient uses support systems to assist with coping. (6,7)
- Patient copes with threat of anxiety by being involved in decisions about care. (8,9,10)
- Patient demonstrates abated physical symptoms of anxiety. (2,3,4,5,6,7,8,9,10)
- Patient performs stress-reduction techniques to avoid anxiety symptoms. (11)

Interventions and rationales

1. Maintain awareness and sensitivity to threat of death experienced by patient *to recognize, respect, and cope with patient's emotions and behaviors.*
2. Thoroughly attend to patient's physical needs, *thus reassuring patient and demonstrating that these needs will continue to be met.*
3. Organize work to spend as much time as possible with patient *to allay fears of being neglected or forgotten.*
4. Provide opportunities for patient to discuss reasons for anxiety. (Without assistance,

some patients will not be able to express their fear of dying.) *By drawing patient out in conversation, you allow communication to proceed at patient's own pace.*

5. Determine patient's level of knowledge about situation *so you can correct any misconceptions.*
6. If patient and caregivers are coping well with their anticipatory grief, allow a family member or close friend to stay with patient *to give them time for reminiscing, sharing, and decision making.*
7. Encourage family member or friend to participate in care *to provide a more supportive environment for patient.*
8. Allow patient to be involved in care-related decisions *because patient has a right to understand and participate in care.*
9. Involve the family in joint planning and decision making with patient *to foster trust between patient and family or caregivers.*
10. Support patient's coping mechanisms *to increase potential for further adaptive behaviors.*
11. Teach stress-reduction techniques, such as meditation, guided imagery, and progres-

sive muscle relaxation, *to stabilize patient psychologically by diminishing sympathetic response to anxiety.*

Documentation

- Patient's statements of anxious feelings
- Patient's perceptions of reasons for anxiety
- Observations of physical signs of anxiety
- Interventions to assist patient with coping
- Family's willingness to participate in patient's care
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

Definition

State of being at risk for aspiration of gastrointestinal or oropharyngeal secretions, food, or fluids into tracheobronchial passages

Assessment

- Neurologic status, including level of consciousness, orientation, and mental status
- Gastrointestinal status, including presence or absence of gag and swallow reflex, inspection of abdomen, abdominal girth, auscultation of bowel sounds, palpation for masses and tenderness, percussion of abdomen, and medications
- Nutritional status, including continuous and intermittent tube feeding
- Respiratory status, including skin color, rate and depth of respiration, cough (productive or nonproductive), auscultation of breath sounds, palpation for fremitus, sputum characteristics (color, consistency, amount, odor), arterial blood gases, chest X-ray

- Vital signs
- Laboratory studies, such as white blood cell count and sputum culture

Risk factors

- Bolus tube feedings or drug administration
- Decreased gastrointestinal motility
- Delayed gastric emptying
- Depressed cough and gag reflexes
- Feeding tubes
- Impaired swallowing
- Increased intragastric pressure
- Overinflated or underinflated tracheostomy or endotracheal tube cuff
- Reduced level of consciousness
- Situations hindering elevation of upper body
- Surgery or trauma to face, mouth, or neck
- Tracheostomy or endotracheal tube
- Wired jaws

Associated medical diagnoses (selected)

Any disease arising in adults that may require surgery with general anesthesia, tube feedings, or artificial airway; cerebrovascular accident; intestinal obstruction; reduced level of consciousness; trauma

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient shows no signs of aspiration. (1,2,4,5)
- Patient tolerates _____ ml of tube feeding. (8,9)
- Patient's temperature remains normal. (3)
- White blood cell count remains normal. (10)
- No pathogens appear in cultures. (10)
- Respiratory secretions are clear and odorless. (1,4,6)
- Auscultation reveals no adventitious breath sounds. (1,4)
- Auscultation reveals bowel sounds. (7)
- Patient and caregiver discuss measures necessary to prevent aspiration. (11)

Interventions and rationales

1. Assess respiratory status at least every 4 hours *for signs of possible aspiration (increased respiratory rate, cough, sputum production, diminished breath sounds).*
2. Monitor and record neurologic status *to detect altered level of consciousness, which could affect intake of food or saliva.*
3. Monitor and record vital signs *to detect signs of aspiration or impaired gas exchange*

resulting from aspiration.

4. Suction as needed *to keep airways clear.* ‡
5. Assess patient for gag and swallow reflex. *Abnormal swallowing may cause aspiration.*
6. Encourage patient to cough and expectorate sputum *to mobilize secretions.* Provide tissues and a paper bag.
7. Auscultate bowel sounds every shift and report changes. *Delayed gastric emptying and elevated intragastric pressure may promote regurgitation of stomach contents.*
8. If patient is receiving tube feedings: ‡
 - a. Assess cuff inflation for patient with artificial airway and adjust appropriately *to protect lower airways from oropharyngeal secretions.*
 - b. Add food coloring to tube feeding if patient has altered state of consciousness, diminished gag reflex, or history of aspiration, *to help monitor gastric secretions for aspiration.*
 - c. Begin regimen with a small, diluted amount as tolerated and ordered, *to allow adjustment to formula osmolality and avoid nausea, vomiting, and diarrhea.* ‡
 - d. Elevate head of bed during and after

feedings unless contraindicated.

- e. Place tube properly before feeding or giving medication *to protect airway.*
 - f. Stop feeding immediately if you suspect aspiration. Apply suction as needed. Turn patient on side *to avoid further aspiration.*
9. Assess need for antiemetic drug *to reduce nausea and vomiting.* Administer and monitor effectiveness. ‡
 10. Review test results *to identify signs of infection,* and report abnormalities.
 11. Explain treatment to patient and caregivers *to encourage compliance.*

Documentation

- Verification of tube placement
- Tolerance of tube feedings
- Residuals of tube feedings
- Vomiting or aspiration
- Breath sounds
- Patient's indication of situations that may lead to aspiration
- Observations of physical findings
- Interventions performed to prevent aspiration
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Definition

Negative perception of self that makes healthful functioning more difficult

Assessment

- Physiologic changes
- Behavioral changes
- Patient's and family's perception of the patient's present health problem
- Patient's usual pattern of coping with stress
- Marital status
- Patient's role in the family
- Patient's past experiences with health problems
- Sleep pattern
- Appetite
- Hobbies and interests
- Occupational history
- Ethnic background and cultural perceptions

Defining characteristics

- Actual change in structure or function
- Hiding or overexposing body part (intentional or unintentional)
- Missing body part
- Nonverbal response to actual or perceived change in structure or function
- Not looking at body part
- Not touching body part
- Trauma to nonfunctioning part
- Verbal response to actual or perceived change in structure or function

Associated medical diagnoses (selected)

Acromegaly; Addison's disease; bone or skin cancer; breast cancer requiring mastectomy; burns; cerebrovascular accident; colitis; conditions requiring colostomy, ileostomy, laryngectomy, limb amputation, radical neck surgery, tracheostomy or ureteroileostomy; Crohn's disease; Cushing's disease; facial trauma or tumors; Graves' disease; rheumatoid arthritis; spinal cord injury

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient acknowledges change in body image. (1,2)
- Patient participates in decisions about various aspects of care (specify). (3,4)
- Patient communicates feelings about change in body image. (5)
- Patient expresses positive feelings about self. (6,7)
- Patient talks with someone who has experienced the same problem. (8)
- Patient demonstrates ability to practice two new coping behaviors. (9,10,11)

Interventions and rationales

1. While assisting with self-care measures, involve patient in discussions that will provide further insights into patient's coping patterns and self-esteem. *Patient's usual coping patterns and self-perception provide baseline data for assessing potential threat of current situation.*
2. Accept patient's perception of self to validate patient's self-perception and provide reassurance that he can successfully overcome crisis.

3. Assess patient's readiness for decision making, then involve him in making choices and decisions related to care. *This gives patient sense of control over environment.*
4. Encourage patient to participate actively in performing care. *This gives patient sense of independence.*
5. Give patient opportunities to voice feelings. *This helps patient ventilate doubts and resolve concerns.*
6. Show patient how bodily functions are improving or stabilizing. *Responding honestly to patient's self-doubts and describing others' successful adaptations to similar situations helps patient feel more confident.*
7. Provide positive reinforcement of patient's efforts to adapt to increase probability that healthy adaptation will continue.
8. Arrange for patient to interact with others who have similar problems. *A support group allows patient to share mutual support and caring with others who can fully understand.*
9. Refer patient to a mental health professional for further counseling. *Referral to psychiatric liaison nurse is indicated when patient is adapting poorly to situation. ‡*

10. Teach patient coping strategies (specify) to help overcome maladaptive coping behaviors.
11. Have patient provide feedback about coping behaviors that seem to work. Reinforce the practice of these behaviors. *This allows nurse to evaluate patient's adaptive abilities. Positive feedback reinforces adaptability and encourages similar behaviors in future.*

Documentation

- Words patient uses to describe self, prostheses, adaptive equipment, limitations
- Observations of patient focusing on or ignoring body part
- Observations of change in structure or function of body part
- Observed responses of patient to change in body part, such as touching or not touching
- Health education or counseling provided to help patient cope with altered body image
- Patient's response to nursing interventions
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Body image disturbance related to distorted internalization of a societal ideal

13a

Definition

Inaccurate self-perception that leads to weight loss in an attempt to conform to an idealized body image

Assessment

- Health history, including previous eating disorders; dieting; history of physical, emotional, or sexual abuse; episodes of emesis
- Physiologic status, including vital signs, weight, appetite
- Exercise pattern
- Psychological status, including expressions of need for control or perceived loss of self-control, behavioral changes, expressions of helplessness, recent emotional crisis, stress, body image
- Perception of ideal feminine form
- Family status, including role performance, perception of role within family
- Use of diuretics and laxatives

Defining characteristics

- Amenorrhea
- Bradycardia
- Change in body structure, body weight, or function
- Decreased blood pressure
- Denial of eating disorder
- Depression
- Dry skin and brittle nails
- Excessive and ritualized exercise
- Excessive need for control of self and environment
- Fear of weight gain
- Hiding body in oversized clothing
- Inability to tolerate cold temperatures
- Irritability
- Lanugo hair
- Lowered body temperature
- Obsession with being organized
- Obsession with food
- Ritualized eating patterns
- Social isolation

Associated medical diagnoses (selected)

Amenorrhea, anorexia nervosa, arrhythmias, bulimia nervosa, dehydration, depression, diarrhea, electrolyte imbalance, growth disturbance, malnutrition, tooth enamel erosion

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient complies with prescribed treatment regimen. (1,2,10)
- Patient expresses feelings associated with food, exercise, weight loss, and medical condition. (3,7,14)
- Patient expresses understanding of the idea that her eating and exercise patterns are self-destructive. (5,6,7)
- Patient asks for help in controlling destructive behavior. (3,6,7)
- Patient participates in decisions related to care and treatment. (4,6,7,8,9,11,13)
- Patient participates in support group for people with eating disorders. (14)
- Patient expresses insight into the reasons behind her eating patterns and other self-destructive behaviors. (6,14)
- Patient learns and implements new coping behaviors. (13,14,15)
- Patient expresses positive feelings about self. (8,12,13)
- Patient expresses satisfaction with parental involvement in care. (16,17,18)

Interventions and rationales

1. Implement the patient's prescribed medical therapy *to help restore health and body function.* ‡
2. Obtain a referral for a psychiatric evaluation *to identify problems related to altered body image, poor self-esteem, and inappropriate coping.*
3. Convey a positive, caring attitude to the patient *to foster a positive relationship.* Take steps to ensure continuity of care throughout her hospital stay *to foster trust.*
4. Encourage the patient to participate in self-care and, as appropriate, to make decisions about therapy *to foster a sense of control and involvement in restoring health.*
5. Tell the patient that you accept her as a person and provide reassurance that she can overcome her problems *to validate self-perception and enhance confidence.*
6. Maintain communication throughout the patient's hospital stay *to assess coping mechanisms and level of self-esteem.*
7. Encourage the patient to express feelings regarding herself, eating, exercise, hospitalization, and medical condition *to clear up mis-*

conceptions and allow the patient to express feelings.

8. Reinforce appropriate behaviors *to encourage the patient to comply with therapy and to participate in care.* Use behavior modification strategies consistently *to enable the patient to predict consequences of behavior.*
9. Avoid using coercive techniques to make patient participate in care or adhere to rules. *Use of coercion may encourage the patient to view manipulative behavior as acceptable.*
10. Without conveying an attitude of mistrust, be mindful for signs of noncompliance with the medical regimen *to monitor for self-destructive behavior.*
11. Inform the patient of her progress throughout hospitalization *to increase her awareness of achievements and motivate her to keep trying.*
12. Help the patient to identify positive aspects of her appearance *to improve self-esteem.*
13. Help direct the patient's need for control away from body image and eating behaviors by encouraging her participation in appropriate

(continued)

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Interventions and rationales (continued)

diversional activities *to channel her energies into new areas in which she can take pride.*

14. Encourage her participation in group discussions with peers who also have eating disorders *to foster insight and group support.*

15. Help the patient identify appropriate coping strategies. Discuss previously effective strategies *to help her substitute them for maladaptive ones.*

16. Encourage parents to demonstrate emotional support for the patient throughout her hospital stay and following discharge *to strengthen the family support system.*

17. Encourage parents to participate in a support group with other parents of children with eating disorders *to provide a forum for expressing feelings and obtaining support from individuals who can understand their concerns.*

18. Teach parents how to detect signs that their child may be relapsing into self-destructive

behaviors *to help them identify the need for early assistance and enhance their confidence in their ability to protect their child from harm.*

Documentation

- Weight (recorded daily or weekly according to agency protocol)
- Amount of food consumed at each meal
- Patient's description of self
- Observations of rituals related to food and exercise
- Participation in and response to support group
- Observations of self-destructive behaviors, such as forced emesis or use of laxatives or diuretics
- Observations of manipulative behaviors
- Coping mechanisms
- Exercise patterns
- Behavior modification techniques used by caregivers

- Patient's response to treatment protocol
- Patient's response to nursing interventions
- Evidence of changes in patient's self-perceptions
- Evaluations for each expected outcome.

Care plan notes

Care plan notes

Definition

State of being at risk for failure to maintain body temperature within normal range

Assessment

- History of present illness
- Age
- Environmental temperature
- Medication history
- Neurologic status, including level of consciousness, sensory status, motor status, and mental status
- Cardiovascular status, including heart rate and rhythm, blood pressure, pulses, capillary refill, and ECG
- Respiratory status, including breath sounds, arterial blood gases, and respiratory rate, depth, and character
- Integumentary status, including temperature, color, and turgor
- Gastrointestinal status, including inspection of abdomen and auscultation of bowel sounds

- Nutritional status, including dietary pattern and current weight
- Psychosocial status, including behavior, mood, financial resources, recent relocation with associated change of climate, and living accommodations
- Support systems, including family, friends, and clergy

Risk factors

- Advanced age
- Altered metabolic rate
- Dehydration
- Exposure to various environmental temperatures
- Inactivity
- Inappropriate clothing for temperature
- Obesity or underweight
- Sedation
- Vasoconstrictor or vasodilator drug therapy
- Vigorous activity

Associated medical diagnoses (selected)

Thermoreceptors in an elderly patient may be impaired by any disease, injury, or degenerative change.

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Body temperature remains normal. (1,2)
- Skin remains warm and dry. (1,2)
- Patient states feelings of comfort. (1,2)
- Patient exhibits no signs of hypothermia or hyperthermia. (1,2,5)
- Patient expresses understanding of factors that cause hypothermia and hyperthermia. (4)
- Patient describes ways to prevent altered body temperature. (4)
- Patient identifies warning signs of hypothermia and hyperthermia. (5)

Interventions and rationales

1. Monitor body temperature every 8 hours or more frequently, as indicated, *to ensure temperature doesn't vary more than 1° F from average normal (98.6° F oral)*. If it does, monitor more frequently.
2. Assess body systems every 8 hours and record results. Report significant changes as they occur *to avoid possible brain damage from hypoxia*.
3. Instruct patient — especially an elderly one — in hypothermia precautions:
 - a. Maintain specific room temperature.

- b. Dress warmly, even when indoors (particularly in bed).
 - c. Ensure adequate food and fluid intake.
 - d. Remain as active as possible.
 - e. Have a friend or neighbor check on the patient every day.
4. Instruct patient in hyperthermia precautions:
 - a. Stay out of direct sunlight.
 - b. Avoid strenuous activity in hot weather.
 - c. Dress in lightweight, loose-fitting clothing that permits perspiration to evaporate. Select pale colors, if possible.
 - d. Drink enough fluids.
 - e. Avoid alcoholic beverages and tobacco. *Because several factors may cause abnormal body temperature—thermoreceptors may be impaired by disease, injury, or degeneration, for example, or the hypothalamus may not respond appropriately—precautions are aimed at maintaining optimal health through modification of environment.*
 5. Instruct patient about warning signs of hypothermia and hyperthermia, such as lethargy,

shivering, nausea, and dizziness, *to prevent complications*.

Documentation

- Patient's perception of the problem—for example, reports of excessive cold or heat
- Observations of risk factors that alter body temperature
- Instructions regarding preventive measures
- Patient's understanding of instructions
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

Definition

State in which mother, infant, or family exhibits proficiency and satisfaction with breastfeeding process

Assessment

- Maternal status, including age and maturity, parity, level of prenatal breastfeeding preparation, past breastfeeding experience, previous postpartal history, physical condition (actual or perceived inadequate milk supply, comfort level), psychosocial factors (apprehension level, body image, stress from family and career, sociocultural views of breastfeeding, emotional support from significant others)
- Infant status, including satisfaction and contentment, growth-rate, age-weight relationship, urinary output, quantity and characteristics of stools, ability to latch onto breasts

Defining characteristics

- Mother positions infant at breast to promote successful latch-on response
- Mother reports satisfaction with breastfeeding process
- Oxytocin release occurs (let-down response or milk-ejection reflex)
- Infant appears eager to nurse and is content after feedings
- Regular and sustained suckling occurs (every 2 to 3 hours)
- Infant eliminates soft stools and a sufficient quantity of unconcentrated urine
- Infant gains adequate weight

Associated medical diagnoses (selected)

Vaginal or cesarean section delivery of term or preterm infant

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Mother breastfeeds infant successfully and experiences satisfaction with breastfeeding process. (1,2,3,5,6,7,8,9)
- Infant feeds successfully on both breasts and appears satisfied. (2,3,5)
- Infant grows and develops in pace with accepted standards. (2,4,5,6)
- Mother continues breastfeeding infant after early postpartal period. (1,2,3,4,5,6,7,8,9)

Interventions and rationales

1. Assess mother's knowledge and experience of breastfeeding *to focus teaching on specific learning needs.*
2. Educate mother and selected support person about breastfeeding techniques:
 - a. Clean hands and breasts before nursing.
 - b. Position infant for feeding (infant should be able to grasp most of areola).
 - c. Change positions to avoid or decrease nipple tenderness.
 - d. Use both breasts at each feeding.
 - e. Remove infant from breast by breaking suction.
 - f. Avoid setting time limits in early stage.

g. Practice breast care. *Greater understanding of techniques improves chances for success.*

3. Teach techniques *to stimulate let-down response.* These include warm showers and compresses, relaxation and guided imagery, infant suckling, holding infant close to breasts, and listening to infant cry.

4. Educate mother about her nutritional needs. She requires a well-balanced diet plus an additional 500 calories and two extra glasses of fluid each day. She should limit caffeine and avoid foods that make her uncomfortable. *Extra calories and fluids help maintain an adequate milk supply.*

5. Teach mother what to expect from breastfeeding infant. The infant should pass 8 to 12 stools and wet 6 to 8 diapers per day. Stools should be soft to liquid and nonodorous. The infant should nurse every 2 to 3 hours and should quiet after nursing and appear generally well. Explain that the infant also requires nonnutritive sucking. *Teaching will prepare mother for care of infant at home.*

6. Assist mother and family in planning for home care. The mother needs to rest when

infant sleeps, practice self-care, learn techniques for expression and storage of breast milk, and recognize signs of engorgement and infection. Family members should understand the importance of helping out. *Mothers often stop nursing once they return home and resume work, usually because of fatigue.*

7. Provide quiet and privacy *to enhance development of breastfeeding skills.*

8. Encourage mother to verbalize concerns about nursing *to reduce anxiety.*

9. Offer information about breastfeeding support groups *to help meet emotional and learning needs.*

Documentation

- Mother's expressions about breastfeeding experience
- Observations of breastfeeding techniques and mother-infant interaction during nursing
- Teaching and instructions given
- Infant growth and weight
- Referrals to support groups
- Mother's plans for nursing after discharge
- Evaluations for each expected outcome.

† Numbers following each outcome correspond to numbered interventions.

Breastfeeding, ineffective

related to dissatisfaction
or difficulty with breastfeeding

16

Definition

State in which mother, infant, or family experience dissatisfaction or difficulty with breastfeeding

Assessment

- Maternal status, including age and maturity, relationships with significant others, previous bonding history, parity, level of prenatal breastfeeding preparation, knowledge or previous breastfeeding experience, physical condition (actual or perceived inadequate milk supply, nipple shape, comfort level), psychosocial impact (apprehension level, body image and perceptions, such stressors as family and career, actual or perceived sociocultural views of breastfeeding, emotional support from significant others)
- Infant status, including satisfaction and contentment, growth rate, age-weight relationship

Defining characteristics

- Abnormal or awkwardly shaped nipple
- Inability of infant to attach to nipple correctly
- Lack of maternal attachment behavior; reluctance to put infant to breast as necessary
- No observable sign of oxytocin release
- Nonsustained suckling at breast
- Obvious infant hunger with little or no weight gain
- Obvious physical discomfort
- Outward evidence of apprehension, stress, fear (postpartum blues)
- Verbal report of inadequate breastfeeding knowledge

Associated medical diagnoses (selected)

Infant anomaly, infant prematurity, maternal nipple anomaly, maternal psychological stress

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Mother expresses physical and psychological comfort with breastfeeding techniques and practice. (1,2,4,5,6)
- Mother shows decreased anxiety and apprehension. (1,2,4,5,6)
- Infant feeds successfully on both breasts and appears satisfied for at least 2 hours after feeding. (1,3)
- Infant grows and thrives. (1,3)
- Mother states at least one resource for breastfeeding support. (6)

Interventions and rationales

1. Educate the mother or other caregiver in breast care and breastfeeding techniques. *This reduces anxiety and enhances proper nutrition for the infant.*
2. Be available yet discreet during breastfeeding. *Assessment of mother's technique can point out problem areas for nurse to concentrate on. Encourage mother's questions to increase understanding and reduce anxiety.*
3. Teach techniques for letdown response:
 - a. warm shower
 - b. breast massage

- c. physically caring for infant
 - d. holding infant close to breasts. *These measures reduce anxiety and facilitate let-down response.*
4. Provide environmental setting conducive to breastfeeding:
 - a. quiet
 - b. private
 - c. comfortable
 - d. decreased external stressors. *A relaxed environment can promote successful breastfeeding.*
 5. Encourage expression of fears and anxieties between mother and other caregivers. *This reduces anxiety and increases mother's sense of control.*
 6. Offer written information, a reading list, or information about breastfeeding support groups *to help meet the mother's emotional and learning needs.*

Documentation

- Mother's expressions of feelings of comfort with breastfeeding ability
- Observations of bonding and breastfeeding processes

- Teaching and instructions given
- Referrals to support groups
- Infant growth and weight
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

Definition

A break in the continuity of breastfeeding resulting from a maternal or neonatal problem

Assessment

- Maternal status, including age and maturity; employment hours; relationships with significant others; parity; level of prenatal breastfeeding knowledge or experience; physical condition (comfort level, nipple shape, presence of infection, use of medication)
- Neonatal status, including age-weight relationship; growth rate; neurologic status; respiratory status; sucking reflex; presence of factors that interfere with proper sucking (cleft lip, cleft palate)

Defining characteristics

- Continued desire on the part of the mother to maintain lactation and provide breast milk for the neonate's nutritional needs
- Failure of the neonate to receive nourishment at breast for some or all feedings
- Lack of knowledge on the mother's part about expressing and storing breast milk
- Separation of mother and infant

Associated medical diagnoses (selected)

Maternal nipple anomaly, maternal or infant illness, maternal psychological stress, neonatal anomaly, neonatal hyperbilirubinemia, prematurity

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Mother expresses her understanding of the factors that necessitate interruption in breastfeeding. (1,2)
- Mother expresses comfort with her decision whether or not to resume breastfeeding. (3)
- Mother expresses and stores breast milk appropriately. (4,5,6,7,8)
- Mother's milk supply is adequate once breastfeeding is resumed. (6,7,8)
- Mother resumes breastfeeding once interfering factors cease. (9)
- Mother obtains relief from discomfort associated with engorgement. (10)

Interventions and rationales

1. Assess the mother's understanding of the reasons for interrupting breastfeeding *to evaluate her need for additional instruction.*
2. Reassure the mother that the neonate's nutritional needs will be met through other methods *to allay her anxiety.*
3. Assess the mother's desire to resume breastfeeding *to help plan interventions.*
4. Provide appropriate educational materials, including audiovisual aids and written materi-

als. *Audiovisual aids demonstrate proper expressing and storing techniques; written material allows the mother to review information at her own pace.*

5. Instruct the mother in techniques for expressing and storing breast milk *to ensure a proper milk supply.*
6. Recommend use of a breast pump according to the following guidelines *to provide maximum stimulation and prolactin production:*
 - a. initiate pumping 24 to 48 hours following delivery
 - b. pump a minimum of five times a day
 - c. pump a minimum of 100 minutes a day
 - d. pump long enough to soften breasts each time, regardless of duration
7. Encourage the mother to save her breast milk in a sterile container and store it in a refrigerator or freezer for future feedings. *Preserving breast milk ensures that neonate receives maternal antibodies, and helps to encourage maternal involvement in neonatal care.*
8. If prolonged pumping is required, encourage use of a piston-style electric pump. *Using an electric pump produces milk with a higher*

fat content than hand pumping.

9. If the mother intends to resume breastfeeding, take the following steps:
 - a. Instruct her in ways to relieve breast engorgement *to prevent discomfort that may keep the neonate from sucking effectively.*
 - b. If appropriate, instruct the mother in use of devices such as a breast shell, *which is designed to alter flat or inverted nipples, a condition that may interfere with successful breastfeeding.*
 - c. Review the mother's daily routine *to advise her how to incorporate breastfeeding into work schedule.*
 - d. Provide her with information about breastfeeding support groups. *Participating in a support group can help the mother obtain needed emotional support and continue learning.*
10. If the mother doesn't intend to resume breastfeeding, advise her to wear a supportive bra, apply ice, and take a mild analgesic, such as acetaminophen, *to alleviate discomfort associated with engorgement.*

(continued)

† Numbers following outcomes refer to interventions.

Documentation

- Factors that necessitated interruption in breastfeeding (reassessed periodically to determine status)
- Mother's expression of feelings about the need to interrupt breastfeeding
- Mother's decision whether to continue breastfeeding when possible
- Patient teaching
- Mother's efforts to ensure appropriate milk supply
- Mother's responses to nursing interventions
- Neonate's growth, weight, and output
- Referrals to support groups
- Evaluations for each expected outcome.

Care plan notes

Care plan notes

Definition

Change in rate, depth, or pattern of breathing that alters normal gas exchange

Assessment

- History of respiratory disorder
- Respiratory status, including rate and depth of respiration, symmetry of chest expansion, use of accessory muscles, presence of cough, anterior-posterior chest diameter, palpation for fremitus, percussion of lung fields, auscultation of breath sounds, pulmonary function studies
- Neurologic and mental status, including level of consciousness and emotional level
- Knowledge, including current understanding of physical condition and physical, mental, and emotional readiness to learn

Defining characteristics

- Abnormal arterial blood gases
- Accessory muscle use
- Altered chest excursion
- Assumption of 3-point position
- Cough
- Cyanosis
- Dyspnea
- Exertional dyspnea
- Fremitus
- Increased anteroposterior diameter of chest wall
- Nasal flaring
- Pursed-lip breathing and prolonged expiratory phase
- Respiratory depth changes
- Tachypnea
- Verbal report of decreased energy or fatigue

Associated medical diagnoses (selected)

Anemia, chronic obstructive pulmonary disease, cirrhosis, congestive heart failure, metabolic acidosis, pulmonary edema

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient's respiratory rate stays within ± 5 of baseline. (1,2,3,4,5,6,7)
- Arterial blood gas levels return to baseline. (1,2)
- Patient reports feeling comfortable when breathing. (1,3,6)
- Patient reports feeling rested each day. (5,6,7)
- Patient demonstrates diaphragmatic pursed-lip breathing. (8)
- Patient achieves maximum lung expansion with adequate ventilation. (2,4,5,6)
- Patient demonstrates skill in conserving energy while carrying out activities of daily living. (3,5,8c,8e)

Interventions and rationales

1. Assess and record respiratory rate and depth at least every 4 hours, *to detect early signs of respiratory compromise*. Maintain arterial blood gas levels according to hospital policy, *to monitor oxygenation and ventilation status*.
2. Auscultate breath sounds at least every 4 hours *to detect decreased or adventitious*

breath sounds; report changes.

3. Assist patient to a comfortable position, such as by supporting upper extremities with pillows, providing over-bed table with a pillow to lean on, or elevating head of bed. *These measures promote comfort, chest expansion, and ventilation of basilar lung fields.*
4. Help patient with activities of daily living, as needed, *to conserve energy and avoid overexertion and fatigue.*
5. Administer oxygen, as ordered, to help relieve respiratory distress. *Supplemental oxygen helps reduce hypoxemia and respiratory distress. ‡*
6. Suction airway, as needed, *to remove secretions.*
7. Schedule necessary activities to provide periods of rest. *This prevents fatigue and reduces oxygen demands.*
8. Teach patient about:
 - a. pursed-lip breathing
 - b. abdominal breathing
 - c. performing relaxation techniques
 - d. taking prescribed medications (ensuring accuracy of dosage and frequency; monitoring side effects)

- e. scheduling activities to avoid fatigue and provide for rest periods. *These measures allow patient to participate in maintaining health status and also improve ventilation. ‡*

Documentation

- Patient's expressions of comfort in breathing, emotional state, understanding of medical diagnosis, and readiness to learn
- Physical findings from pulmonary assessment
- Interventions carried out and patient's responses to them
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Definition

Change in the rate, depth, or pattern of breathing that alters normal gas exchange

Assessment

- History of medical or surgical problem that causes ineffective breathing
- Respiratory status, including rate and depth of respiration, symmetry of chest expansion, use of accessory muscles, presence of cough, anterior-posterior chest diameter, palpation for fremitus, percussion of lung fields, auscultation of breath sounds, and arterial blood gases
- Neurologic status, including level of consciousness and sensory and motor status
- Psychosocial status, including willingness to cooperate with treatment, coping mechanisms, and knowledge level (current understanding of physical condition)

Defining characteristics

- Accessory muscle use
- Altered chest excursion
- Altered depth of respiration
- Anxiety
- Arterial blood gas abnormalities
- Cyanosis
- Dyspnea
- Fremitus
- Inability to cough
- Nasal flaring
- Tachypnea
- Verbal report of painful respiration

Associated medical diagnoses (selected)

Chest wall injury, pericarditis, pleural effusion, pleurisy, pneumonia, pneumothorax, pulmonary embolus, rib or vertebral fractures

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient's respiratory rate stays within ± 5 of baseline. (1,2,4,10)
- Arterial blood gas levels remain normal. (1,4,10,12)
- Patient achieves comfort without depressing respirations. (3)
- Patient uses incentive spirometer or other respiratory device every 2 hours, or as ordered. (2,3,5,6,7,8)
- Auscultation reveals no adventitious breath sounds. (1,7,8,9)
- Patient states understanding of importance of taking deep breaths. (5,6,7)
- Patient practices relaxation techniques _____ (specify) times a day. (11)
- Patient reports ability to breathe comfortably. (3,4,6,10,11,13)

Interventions and rationales

1. Assess and record respiratory status at least every 4 hours *to detect early signs of compromise*. Maintain arterial blood gases according to hospital policy *to monitor oxygenation and ventilation status*.
2. Assess for pain every 3 hours. *Pain re-*

duces respiratory effort and ventilation.

3. Give pain medication, as ordered, to allow maximal chest expansion. Record effectiveness, and monitor respiratory depression induced by narcotic analgesic, *to guide further therapy.* ‡
4. Assist patient to a comfortable position that also allows for maximal chest expansion: Fowler's position, for example, or leaning on overbed table with pillow *will enhance chest expansion.*
5. Assist patient in using incentive spirometer or other device, as ordered, *to ensure proper use and help prevent atelectasis.* ‡
6. Teach patient how to splint chest while coughing. Keep extra pillow for patient's use. *Splinting reduces pain during coughing.*
7. Perform chest physiotherapy to aid mobilization and secretion removal, if ordered. *Percussion, vibration, and postural drainage enhance airway clearance and respiratory effort.* ‡
8. Provide rest periods between breathing enhancement measures *to avoid fatigue.*
9. Encourage patient to use an incentive spirometer independently. Praise patient's efforts,

to encourage compliance. ‡

10. Provide oxygen, as ordered, *to help relieve respiratory distress caused by hypoxemia.* ‡
11. Teach relaxation techniques to help reduce anxiety. Guided imagery, progressive muscle relaxation, breathing exercises, and meditation *reduce pain and anxiety and enhance patient's sense of self-control.*
12. Change patient's position frequently *to maximize comfort.*
13. Encourage patient to discuss fears *to help reduce anxiety.*

Documentation

- Patient's reports of pain
- Patient's perception of need to take deep breaths, cough, etc.
- Patient's expression of the effectiveness of pain medication
- Observations of physical findings
- Effectiveness of medications
- Descriptions of patient's efforts to take deep breaths and cough
- Interventions performed to enhance patient's ability to breathe effectively
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Cardiac output, decreased
related to reduced stroke volume
as a result of electrophysiologic problems

20

Definition

Cardiovascular or respiratory symptoms resulting from insufficient blood being pumped by the heart

Assessment

- Mental status, including orientation and level of consciousness
- Cardiovascular status, including history of arrhythmias and syncope, jugular vein distention, hepatjugular reflux, heart rate and rhythm, heart sounds, blood pressure, peripheral pulses, ECG, exercise ECG, echocardiogram, phonocardiogram, serum digitalis levels, and skin color, temperature, and turgor
- Respiratory status, including respiratory rate and depth, breath sounds, chest X-ray, and arterial blood gases
- Renal status, including weight, intake and output, urine specific gravity, and serum electrolytes

Defining characteristics

- Arrhythmias; ECG changes
- Cold, clammy skin
- Cyanosis
- Decreased peripheral pulses
- Dizziness
- Dyspnea
- Electromechanical cardiac disorders
- Fatigue
- Jugular venous distention
- Mental status changes
- Pallor of skin and mucous membranes
- Syncope
- Variations in hemodynamic reading
- Vertigo

Associated medical diagnoses (selected)

Acute myocardial infarction, Adams-Stokes syndrome, carotid sinus syndrome, chronic heart block, congestive heart failure, digitalis toxicity, electrolyte imbalance, sick sinus syndrome

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient maintains hemodynamic stability. Pulse not less than _____, not greater than _____. Blood pressure not less than _____, not greater than _____. (1,2,3,4)
- Skin remains warm and dry. (3)
- Dyspneic episodes decreased or absent. (4,5)
- Signs of dizziness or syncope absent. (6)
- No complaint of chest pain. (7,8,9)
- Patient practices stress-reduction techniques every 2 hours. (10,11)
- Cardiac output remains adequate. (1)
- Patient lacks arrhythmias. (1-15)
- Patient understands symptoms, diet, medication, and activity level. (16)

Interventions and rationales

1. Monitor apical and radial pulse at least every 4 hours, *to better detect arrhythmias*. Immediately report abnormal pulse rates.
2. Note pulse rhythm at least every 4 hours and report irregularities. *Arrhythmias may indicate cardiac arrest or other complications*.
3. Assess skin temperature every 4 hours. *Cool, clammy skin may indicate decreased cardiac output*.

4. Assess respiratory status at least every 4 hours. Report complaints of dyspnea or restlessness. *Adventitious breath sounds or dyspnea may indicate fluid buildup in lungs and pulmonary capillary bed (as in congestive heart failure)*.
5. Administer oxygen, as ordered, *to increase supply to myocardium*. ‡
6. Report complaints of dizziness or syncope promptly; *these may indicate cerebral hypoxia*.
7. Tell patient to report chest pain right away, *as it may signal myocardial hypoxia or injury*.
8. Plan patient's care to avoid overexertion, *which increases myocardial oxygen demand*.
9. Change patient's position frequently *to promote comfort and avoid tachycardia and other sympathetic responses*.
10. Teach patient how to perform stress-reduction techniques *to allay anxiety and avoid cardiac complications*.
11. Remind patient to practice stress-reduction techniques every 2 hours while awake *to help internalize learned techniques*.
12. Give antiarrhythmic drugs as prescribed *to reduce or abolish arrhythmias*. Monitor for adverse effects. ‡

13. Instruct patient to avoid straining during bowel movements, *which may cause bradycardia and decreased cardiac output*.
14. Administer stool softeners as prescribed *to reduce straining at stool*. ‡
15. Carry out the medical care plan as ordered. *Collaborative practice enhances care*. ‡
16. Teach patient about: reportable symptoms (such as chest pain, palpitations, weakness, dizziness, syncope); prescribed diet; medications (name, dosage, frequency, therapeutic effects, adverse effects); and activity level. ‡ *These measures let patient and caregivers participate in patient's care, and help patient make informed decisions about health status*.

Documentation

- Patient's symptoms
- Observation of physical findings
- Incidents of chest pain, including location, character, duration, and treatment
- Patient's tolerance for activity
- Interventions to control or monitor symptoms and patient's response
- Patient teaching
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Cardiac output, decreased

related to reduced stroke volume
as a result of mechanical or structural problems

21

Definition

Cardiovascular or respiratory symptoms resulting from insufficient blood being pumped by the heart

Assessment

- Mental status, including orientation and level of consciousness
- Cardiovascular status, including history of valvular disorder, congenital heart disease, or myopathy; skin color, temperature, and turgor; jugular vein distention; hepatojugular reflux; heart rate and rhythm; heart sounds; blood pressure; peripheral pulses; ECG; exercise ECG; echocardiogram; and phonocardiogram
- Respiratory status, including respiratory rate and depth, breath sounds, chest X-ray, and arterial blood gases
- Renal status, including weight, intake and output, and urine specific gravity

Defining characteristics

- Abnormal breath sounds
- Anuria
- Arrhythmias; ECG changes
- Ascites
- Cold, clammy skin
- Cough
- Crackles
- Cyanosis
- Decreased peripheral pulses
- Dyspnea
- Fatigue
- Frothy sputum
- Jugular vein distention
- Liver engorgement and tenderness
- Mechanical or structural cardiac abnormalities
- Mental status changes
- Oliguria
- Orthopnea
- Pallor of skin and mucous membranes
- Variations in hemodynamic reading

Associated medical diagnoses (selected)

Anaphylactic shock, anemia, angina, aortic stenosis, aortic insufficiency, bacterial endocarditis, cardiogenic shock, congestive heart failure, cor pulmonale, hypovolemic shock, mitral insufficiency, mitral stenosis, myocardial infarction, neurogenic shock, Paget's disease, papillary muscle syndrome, pericarditis, pulmonary edema, pulmonary embolism, renal failure, respiratory failure, septic shock, tetralogy of Fallot, thyrotoxicosis

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient attains hemodynamic stability. Pulse not less than _____ and not greater than _____. Blood pressure not less than _____ and not greater than _____. (1,2,13)
- Patient exhibits no arrhythmias. (1,2,4)
- Skin remains warm and dry. (1,2,7)
- Patient exhibits no pedal edema. (3,5,6)
- Patient achieves activity within limits of prescribed heart rate. (8,9)
- Patient expresses sense of physical comfort after activity. (2,11)
- Heart's workload diminishes. (8,9,10,11)
- Patient maintains adequate cardiac output. (1,2,3,4,14)
- Patient performs stress-reduction techniques every 4 hours while awake. (11)
- Patient states understanding of signs and symptoms, prescribed activity level, diet, and medications. (12,13,14,15)

Interventions and rationales

1. Monitor and record level of consciousness, heart rate and rhythm, and blood pressure at least every 4 hours, or more often if necessary, *to detect cerebral hypoxia possibly re-*

sulting from decreased cardiac output.

2. Auscultate heart and breath sounds at least every 4 hours. Report abnormal sounds as soon as they develop. *Extra heart sounds may indicate early cardiac decompensation; adventitious breath sounds may indicate pulmonary congestion and diminished cardiac output.*

3. Measure intake and output accurately and record. *Falling urine output without falling fluid intake may indicate decreased renal perfusion, possibly from decreased cardiac output.*

4. Promptly treat life-threatening arrhythmias. ‡

5. Weigh patient daily before breakfast *to detect fluid retention.*

6. Inspect for pedal or sacral edema *to detect venous stasis and reduced cardiac output.*

7. Provide skin care every 4 hours *to enhance skin perfusion and venous flow.*

8. Gradually increase patient's activities within limits of prescribed heart rate *to allow heart to adjust to increased oxygen demand.* Monitor pulse rate before and after activity *to compare rates and gauge tolerance.* ‡

9. Plan patient's activities *to avoid fatigue and increased myocardial workload.*

10. Maintain dietary restrictions, as ordered, *to reduce risk of cardiac disease.* ‡

11. Teach patient stress-reduction techniques, *to reduce patient's anxiety and provide a sense of control.*

12. Explain all procedures and tests.

13. Teach patient about: chest pain and other reportable symptoms; prescribed diet; medications (name, dosage, frequency, therapeutic effects, adverse effects); prescribed activity level; simple methods for lifting and bending; and stress-reduction techniques. ‡ *These measures involve patient and family in care.*

14. Carry out medical care plan, as ordered. *Collaborative practice enhances overall care.* ‡

15. Administer oxygen, as ordered, *to increase supply to myocardium.* ‡

Documentation

- Patient's needs and perception of problem
- Observations of physical findings
- Patient's response to activity
- Development of skills related to diet, medication, activity, and stress management
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Definition

Caregiver's perceived difficulty in providing care

Assessment

- Caregiver's physical and mental status, including chronic health problems, self-care abilities, mobility limitations, and level of cognitive function
- Care recipient's physical and mental status, including illness, self-care limitations, mobility limitations, and level of cognitive function
- Support systems, including financial resources, family and friends, community services, and health-related services such as geriatric day care, home health aides
- Home environment, including layout of home, structural barriers, need for equipment or assistive devices, availability of transportation
- Cultural, ethnic, and religious background
- Perceived and actual obligations of caregiver
- Caregiver's personal strengths, including

coping and problem-solving abilities, participation in diversional activities or hobbies

Defining characteristics

- Caregiver reports:
 - a. difficulty performing specific caregiving activities, such as bathing, cleaning up after incontinence, managing pain
 - b. feeling a sense of loss because care recipient has changed drastically
 - c. feeling depressed
 - d. feeling that providing care interferes with other important aspects of life, including career, family, and social activities
 - e. feeling stress or anxiety in relationship with care recipient
 - f. feeling that other family members aren't helping sufficiently or showing enough appreciation of caregiver's efforts
 - g. not having sufficient resources (time, emotional strength, physical energy, help from others) to provide care

h. worrying about such possibilities as the care recipient's deteriorating health and emotional state, institutionalization of the care recipient, or the inability to continue to provide care

Associated medical diagnoses (selected)

Acquired immunodeficiency syndrome (AIDS); Alzheimer's disease; amyotrophic lateral sclerosis; cancer; cerebrovascular accident; cerebral palsy; chronic obstructive pulmonary disease; congestive heart failure; dementia; drug or alcohol addiction; end-stage renal, cardiac, or pulmonary disease; Huntington's disease; muscular dystrophy; multiple sclerosis; paralysis; Parkinson's disease; schizophrenia

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Caregiver describes current stressors. (1)
- Caregiver identifies stressors that can and cannot be controlled. (2)
- Caregiver identifies formal and informal sources of support. (4,5,6)
- Caregiver reports increased ability to cope with stress. (1,2,3,4,5,6,7,8)

Interventions and rationales

1. Help the caregiver to identify current stressors *to evaluate the causes of role strain.*
2. Using a nonjudgmental approach, help the caregiver evaluate which stressors are controllable and which are not *to begin to develop strategies to reduce stress.*
3. Encourage the caregiver to discuss coping skills used to overcome similar stressful situations in the past *to build confidence for managing the current situation.*
4. Encourage the caregiver to participate in a support group. Provide information on an organization such as the Alzheimer's Disease and Related Disorders Association, Children of Aging Parents, or the referral service of the community AIDS task force *to foster mutual*

support and provide an opportunity for the caregiver to discuss personal feelings with empathetic listeners.

5. Help the caregiver identify informal sources of support, such as family members, friends, church groups, and community volunteers *to provide resources for obtaining an occasional or regularly scheduled respite.*

6. Help the caregiver to identify available formal support services such as home health agencies, municipal or county social services, hospital social worker, doctors, clinics, day care centers *to enhance coping by providing a reliable structure for support.*

7. If the caregiver seems overly anxious or distraught, gently point out the facts about the care recipient's mental and physical condition. *Many times, especially if the care recipient is a family member, the caregiver's perspective is clouded by a long history of emotional involvement. Your input may help the caregiver view the situation more objectively.* If you believe that excessive emotional involvement is hindering the caregiver's ability to function, consider recommending Co-dependent's Anonymous, a support group for people

whose preoccupation with a relationship leads to chronic suffering and diminished effectiveness *to provide support.*

8. Suggest ways for the caregiver to use time more efficiently. For example, the caregiver may be able to save time by filling out insurance forms while visiting and chatting with the care recipient. *Better time management may help the caregiver reduce stress.*

Documentation

- Stressors identified by caregiver (perceived and actual)
- Observations of caregiver's response to stressful situations
- Referrals provided
- Caregiver's use of informal and formal support systems
- Coping strategies identified by caregiver and nurse
- Evidence of improvement in caregiver's ability to cope
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

Definition

Caregiver's vulnerability to experiencing difficulty in providing care

Assessment

- Caregiver's physical and mental status, including chronic health problems, self-care abilities, mobility limitations, and level of cognitive function
- Care recipient's physical and mental status, including illness, self-care limitations, mobility limitations, and level of cognitive function
- Support systems, including financial resources, family and friends, community services, health-related services such as geriatric day care, home health aids
- Home environment, including structural barriers, layout of home, need for presence of equipment or assistive devices, availability of transportation
- Cultural, ethnic, and religious background
- Perceived and actual obligations of caregiver

- Caregiver's personal strengths, including usual coping and problem-solving abilities, participation in diversional activities or hobbies

Risk factors

- Developmental risk factors
 - a. Lack of preparedness for caregiver role—for example, a young adult who must unexpectedly care for a middle-aged parent
 - b. Developmental delay or disability of the care recipient or caregiver
- Pathophysiologic risk factors
 - a. Cognitive problems caused by brain dysfunction in care recipient
 - b. Drug or alcohol addiction
 - c. Severe illness
 - d. Unpredictable illness course or instability in care recipient's health
- Psychological risk factors
 - a. Co-dependency
 - b. Deviant, bizarre behavior on part of the care recipient
 - c. Evidence of dysfunctional family coping patterns that existed before the caregiving situation
 - d. Evidence of poor coping ability on the part of the caregiver
 - e. Evidence of psychological problems in the care recipient
 - f. Poor relationship between caregiver and care recipient
- Situational risk factors
 - a. Competing role commitments on the part of caregiver
 - b. Discharge of family member with significant home care needs
 - c. Inadequate environment or facilities for providing care
 - d. Isolation of caregiver
 - e. Lack of experience on part of caregiver
 - f. Lack of respite or recreation for caregiver
 - g. Long duration of caregiving anticipated
 - h. Numerous, complex caregiving tasks

(continued)

Risk factors (continued)

- i. Presence of abuse or violence
- j. Simultaneous occurrence of other events that cause stress for family, such as significant personal loss, natural disaster, or economic hardship

Associated medical diagnoses (selected)

Acquired immunodeficiency syndrome (AIDS); Alzheimer's disease; amyotrophic lateral sclerosis; cancer; cerebrovascular accident; cerebral palsy; chronic obstructive pulmonary disease; congestive heart failure; dementia; drug or alcohol addiction; end-stage renal, cardiac, or pulmonary disease; Huntington's disease; muscular dystrophy; multiple sclerosis; paralysis; Parkinson's disease; schizophrenia

Expected outcomes †

- Caregiver identifies current stressors. (1)
- Caregiver identifies appropriate coping strategies and states plans to incorporate strategies into daily routine. (2,7)
- Caregiver states intention to contact formal and informal sources of support. (3,4,6)

- Caregiver states intention to incorporate recreational activities into daily routine. (5)
- Caregiver reports satisfaction with ability to cope with stress caused by caregiving responsibilities. (1,2,3,4,5,6)

Interventions and rationales

1. Help the caregiver identify current stressors. Ask whether stress is likely to increase or decrease in the future *to evaluate the risk for caregiver role strain*.
2. Encourage the caregiver to discuss coping skills used to overcome similar stressful situations in the past *to reinforce the caregiver's confidence in her ability to manage the current situation and explore ways to apply coping strategies before the caregiver becomes overwhelmed*.
3. Help the caregiver identify informal sources of support, such as family members, friends, church groups, and community volunteers *to plan for an occasional or regularly scheduled respite*.
4. Help the caregiver to identify available formal support services such as home health agencies, municipal or county social services,

hospital social worker, doctors, clinics, day care centers *to assist the caregiver and thereby lessen the risk of strain*.

5. Encourage the caregiver to discuss hobbies or diversional activities. *Incorporating enjoyable activities into the daily or weekly schedule will discipline the caregiver to take needed breaks from caregiving responsibilities and thereby diminish stress*.

6. Encourage the caregiver to participate in a support group. Provide information on an organization such as the Alzheimer's Disease and Related Disorders Association, Children of Aging Parents, or the referral service of the community AIDS task force *to foster mutual support and provide an outlet for expressing feelings before frustration becomes overwhelming*.

7. Suggest ways for caregiver to use time efficiently; for example, the caregiver may be able to save time by filling out insurance forms while visiting and chatting with the care recipient. *Better time management may help the caregiver reduce stress*.

(continued)

† Numbers following outcomes refer to interventions.

Documentation

- Current stressors identified by caregiver
- Risk factors for caregiver role strain identified by nurse (developmental, pathophysiologic, psychological, situational)
- Caregiver's statements indicating intention to take action to minimize stress, such as seeking help from support services, participating in a caregiver support group, and scheduling time for recreational activities
- Coping strategies identified by caregiver and nurse
- Observations of caregiver's response to stressful situations
- Referrals provided
- Evaluations for each expected outcome.

Care plan notes

Care plan notes

Definition

Interruption of normal bowel movements resulting in infrequent or absent stools

Assessment

- History of bowel disorder or surgery
- Gastrointestinal status, including nausea and vomiting, usual bowel habits, change in bowel habits, laxative use, stool characteristics (color, amount, size, consistency), pain, inspection of abdomen, auscultation of bowel sounds, palpation for masses and tenderness, percussion for tympany and dullness, upper GI series, barium enema, sigmoidoscopy
- Nutritional status, including dietary intake, appetite, current weight, change from normal weight
- Fluid and electrolyte status, including intake and output, skin turgor, urine specific gravity, serum electrolytes
- History of ingesting nonfood items (in psychiatric patients)

Defining characteristics

- Abdominal distention
- Abdominal pain
- Amount of stool less than usual
- Clinical evidence of gastrointestinal obstruction
- Decreased appetite
- Fever
- Flatulence
- Frequency of bowel movements less than usual
- Hard, formed stools (change in stool diameter)
- Palpable abdominal mass
- Projectile vomiting
- Seizures (in controlled seizure patients)
- Straining during defecation
- Vomiting fecal material

Associated medical diagnoses (selected)

Adhesions, cancer of large bowel, diverticulitis, impaction, intussusception, mechanical intestinal obstruction, mesenteric thrombosis, neurogenic intestinal obstruction, paralytic ileus, peritonitis, spinal cord injury, strangulated hernia, vascular intestinal obstruction, volvulus

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient returns to usual bowel pattern. (1,2,3,4)
- Patient maintains fluid balance; intake equals output. (2,4)
- Patient displays normal bowel sounds. (3)
- Patient expresses pain relief or comfort. (5)
- Patient stops vomiting through use of antiemetics or gastrointestinal tube. (5,6,7)
- Patient states understanding of surgical procedure. (8)
- Patient or caregiver demonstrates use of ileostomy or colostomy equipment. (9,10)
- Patient states acceptance of bowel diversion. (11)
- Patient or caregiver discusses effect of bowel diversion on life-style. (11,12)

Interventions and rationales

1. Carefully monitor and record frequency and characteristics of stool *to form the basis of an effective treatment plan.*
2. Record intake and output accurately *to ensure correct fluid replacement therapy.* Report any imbalance.
3. Auscultate bowel sounds and record every

4 hours. Report significant changes. *Absent or diminished bowel sounds may indicate peritoneal irritation or intestinal obstruction.*

4. Record patient's weight daily *to detect possible fluid retention, food malabsorption, or increased adaptation requirements on body processes.*

5. Administer pain medication and antiemetics, as ordered. Monitor effectiveness *to determine need for alternative treatment.* ‡

6. Promote patient comfort during vomiting episodes by providing oral care and removing vomitus promptly. Carefully record amount and characteristics of vomitus *to ensure accurate intake and output records.*

7. Provide oral and nasal care every 4 hours while gastrointestinal tube is present. Keep nostrils clean and moist *to prevent irritation.* ‡

8. Prepare patient for surgery: ‡

- a. Give preoperative instruction for abdominal surgery *to reduce patient's anxiety and increase trust.*
- b. Inform patient about ileostomy, colostomy, or colectomy, as indicated, *to reduce anxiety.*

9. Instruct patient and caregivers in the use of ileostomy or colostomy equipment *to promote familiarity and establish therapeutic relationship.*

10. Have patient and caregivers demonstrate use of equipment *to encourage feeling of shared responsibility.*

11. Encourage patient and family to express feelings and concerns about changes in body image *to help them learn to cope.*

12. Encourage visits to patient by persons from ileostomy or colostomy clubs and other support groups, *to provide patient with additional health care resources.*

Documentation

- Patient's expressions of concern about vomiting, gastrointestinal tube, or surgery
- Observation of characteristics of emesis and stool, intake and output, weight, bowel sounds, and condition of oral cavity
- Patient's reaction and adaptation to ileostomy or colostomy
- Patient's and caregivers' participation in care and response to instruction
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Definition

Interruption of normal bowel movements resulting in infrequent or absent stools

Assessment

- History of bowel disorder or surgery
- Gastrointestinal status, including nausea and vomiting, usual bowel habits, change in bowel habits, laxative use, stool characteristics (color, amount, size, consistency), pain, inspection of abdomen, auscultation of bowel sounds, palpation for masses and tenderness, and percussion for tympany and dullness
- Nutritional status, including dietary intake, appetite, current weight, and change from normal weight
- Fluid status, including fluid intake, urine output, urine specific gravity, and skin turgor
- Knowledge, including ability and motivation to change current patterns, and understanding of relationship between intake, bulk, and constipation

Defining characteristics

- Amount of stool less than usual
- Decreased appetite
- Dehydration
- Fever
- Frequency less than usual pattern
- Hard, formed stools
- Straining during defecation
- Verbal report of decreased intake of fluid, food, or bulk

Associated medical diagnoses (selected)

This diagnosis may pertain to all patients undergoing periods of restricted food or fluid intake and those with anorexia nervosa or coma.

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Elimination pattern returns to normal. (1,2,3,4,5,6,7,8)
- Patient experiences bowel movement every _____ day(s). (1,4,6)
- Patient consumes high-fiber or high-bulk diet, unless contraindicated. (7,8)
- Patient maintains oral fluid intake of 2,500 ml daily, unless contraindicated. (2,3)
- Patient states understanding of relationship of dietary intake and bulk to constipation. (7,8)
- Patient lists foods needed to prevent recurrence of problem, such as fruit, fruit juices, whole grain bread, and cereals. (7,8)

Interventions and rationales

1. Monitor and record frequency and characteristics of stool. *Careful monitoring forms the basis of an effective treatment plan.*
2. Record intake and output accurately to ensure correct fluid replacement therapy.
3. Unless contraindicated, encourage fluid intake of 2,500 ml daily to ensure correct fluid replacement therapy.
4. Place patient on bedpan or commode at specific time(s) daily, as close to usual evacu-

ation time (if known) as possible, to aid adaptation to routine physiologic function.

5. Administer laxative or enema, as ordered, to promote elimination of solids and gases from GI tract. Monitor effectiveness. ‡

6. Teach patient to gently massage along the transverse and descending colon to stimulate the bowel's spastic reflex and aid stool passage.

7. Consult with dietitian about increasing fiber and bulk in diet to maximum prescribed by doctor. *This will improve intestinal muscle tone and promote comfortable elimination.* ‡

8. Instruct patient and family in the relationship of diet, exercise, and fluid intake to constipation. Develop plan and provide for mild exercise periods. *These measures promote muscle tone and circulation and discourage departure from prescribed diet.*

Documentation

- Patient's expressions of concern about constipation, dietary changes, laxative use, and bowel pattern
- Observations of food and fluid intake and stool characteristics

- Patient's expression of understanding of relationship between constipation and dietary intake of fluid and bulk
- Patient's response to nursing interventions
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Definition

Interruption of normal bowel movements resulting in infrequent or absent stools

Assessment

- History of bowel disorder or surgery
- Gastrointestinal status, including nausea and vomiting, usual bowel habits, change in bowel habits, stool characteristics (color, amount, size, consistency), pain, inspection of abdomen, auscultation of bowel sounds, palpation for masses and tenderness, percussion for tympany and dullness, laxative or enema use, medications (iron, narcotics)
- Nutritional status, including dietary intake, appetite, current weight, and change from normal weight
- Activity status, type and duration of exercise, and occupation (sedentary, restricted access to bathroom)
- Knowledge, including understanding of need for regular bowel habits, ability and motivation

to change current patterns, and understanding of relationship between laxative and enema use, activity, and constipation

Defining characteristics

- Amount of stool less than usual
- Failure to respond to urge to defecate
- Frequency less than usual pattern
- Habitual or daily use of laxatives or enemas
- Hard, formed stools
- Interference with daily living
- Palpable abdominal mass (impaction)
- Rectal fullness or pressure
- Straining during defecation

Associated medical diagnoses (selected)

Atonic colon, depression, diverticulitis, diverticulosis, fecal impaction, hemorrhoids, spastic or irritable colon

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Elimination returns to normal. (1,2,3,4)
- Patient moves bowels every _____ day(s) without laxative or enema. (1,4,5,7)
- Patient states understanding of causative factors of constipation. (6,7,8)
- Patient gets regular exercise. (7)
- Patient describes changes in personal habits to maintain normal elimination pattern. (3,6,7)
- Patient states plans to seek help to resolve emotional or psychological problems. (8)

Interventions and rationales

1. Monitor and record frequency and characteristics of stool. *Careful monitoring forms the basis of an effective treatment plan.*
2. Administer laxatives or enemas, as ordered, *to promote elimination.* Monitor effectiveness. ‡
3. Provide privacy for elimination. Encourage establishment of daily schedule, *to aid adaptation to routine physiologic function.*
4. Weigh patient weekly and record the results *to detect fluid loss or retention, food malabsorption, or increased adaptation requirement on body processes.*

5. Encourage intake of high-fiber foods, such as bananas, prunes, dates, figs, and whole grain cereals and breads, *to supply bulk for normal elimination.*
6. Consult with dietitian and encourage adherence to a diet modification plan *to discourage departure from prescribed diet.*
7. Teach patient about:
 - a. effects of long-term laxative or enema use *to avoid damaging intestinal mucosa*
 - b. need for diet high in fiber, bulk, and fluid *to soften stool and stimulate intestinal mucosa ‡*
 - c. importance of responding to defecation urge *to avoid pressure and discomfort in lower GI tract*
 - d. selection of regular exercise program and adherence to it.
8. Make referral to psychiatric liaison nurse, community agencies, or support groups, *to provide additional health care resources to patient and family.*

Documentation

- Patient's expressions of concern about change in diet, activity level, use of laxatives or enemas, and bowel pattern
- Observations of characteristics of stool, diet, and activity tolerance
- Patient teaching about diet, exercise, and management of constipation
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Definition

Elimination pattern characterized by hard, dry stool resulting from delayed passage of food residue

Assessment

- History of neurologic or psychiatric disorder
- History of thyroid problems
- History of familial multiple polyposis
- Fluid and electrolyte status, including intake and output, skin turgor, urine specific gravity, and mucous membranes
- Age
- Gastrointestinal status, including nausea and vomiting, usual bowel pattern, bowel habits and changes in bowel habits, stool characteristics (color, amount, size, consistency), pain, auscultation of bowel sounds, palpation for masses or tenderness, percussion for tympany and dullness, laxative or enema use, medications (including iron, narcotics), rectal exam

- Nutritional status, including dietary intake, appetite, current weight and change from normal, tolerance and intolerance for foods
- Activity status, including type and duration of exercise, occupation (sedentary, restricted access to bathroom), change in activities
- Psychosocial status, including personality, stressors (finances, job, marital discord), coping mechanisms, support systems (family, significant other)
- Life-style
- Knowledge level

Defining characteristics

- Abdominal distention
- Abdominal pain
- Decreased frequency of bowel movement
- Hard, dry stool
- Headache
- Impaired appetite
- Painful defecation

- Palpable mass
- Rectal pressure
- Straining during defecation

Associated medical diagnoses (selected)

Anxiety, cerebrovascular accident, depression, hypocalcemia, hypokalemia, hypothyroidism, ulcerative colitis

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Bowel pattern returns to normal. (3,5,6,7,9)
- Bowel movement occurs every _____ day(s) without laxatives, enemas, or suppositories. (3,5,6)
- Patient maintains oral fluid intake of 3,000 ml daily, unless contraindicated. (8)
- Patient states understanding of factors causing constipation. (1,4,8)
- Patient exercises regularly. (2)
- Patient states intention to seek additional resources, if necessary. (10)

Interventions and rationales

1. Correct dietary habits to include adequate fluids, fresh fruits, and whole-grain cereals and breads, *which supply necessary bulk for normal elimination.*
2. Encourage patient to engage in active daily exercise, such as brisk walking, *to strengthen muscle tone and stimulate circulation.*
3. Encourage patient to evacuate at regular times, *to encourage adaptation and routine physiologic function.*
4. Urge patient to avoid taking laxatives if possible, or to gradually decrease their use, *to*

avoid further trauma to intestinal mucosa.

5. Inform patient not to expect to have a bowel movement every day or even every other day, *to avoid use of poor health practices to stimulate elimination.*

6. Establish and implement an individualized bowel regimen based on patient's needs. *Knowledge of normal body functions will improve patient's understanding of problem.*

7. Instruct patient to avoid straining during elimination, *to avoid tissue damage, bleeding, and pain.*

8. If not contraindicated, raise patient's fluid intake to about 3,000 ml daily *to increase functional capacity of bowel elimination.*

9. Tell patient that abdominal massage may help relieve discomfort and promote defecation. *This procedure triggers bowel's spastic reflex.*

10. Obtain referral to a dietitian *for nutritional counseling.*

Documentation

- Patient's expression of concern about use of laxatives, enemas, or suppositories to establish bowel pattern
- Bowel movements
- Patient teaching about constipation management
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to intervention.

Definition

State in which an individual makes a self-diagnosis of constipation and ensures daily bowel movements through use of laxatives, enemas, or suppositories

Assessment

- Family history of constipation
- History of psychiatric disorders
- Fluid and electrolyte status, including intake and output, skin turgor, urine specific gravity, mucous membranes
- Marital status
- Gastrointestinal status, including bowel habits, change in bowel habits, stool characteristics (color, amount, size, consistency), pain, auscultation of bowel sounds, laxative or

enema use (time and duration), family habits concerning bowel movements, rectal examination

- Nutritional status, including dietary intake and appetite
- Activity status
- Psychosocial status, including personality, stressors (finances, job, marital discord, coping mechanisms), support systems (family, others), life-style, knowledge level

Defining characteristics

- Cultural and family health beliefs
- Daily laxative use
- Expectation of bowel movement at same time every day
- Faulty appraisal
- Impaired thought processes

Associated medical diagnoses (selected)

Anal eroticism, thought process disorders

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient decreases use of laxatives, enemas, or suppositories. (1,4)
- Patient states understanding of normal bowel function. (1,3,4,5,7,8)
- Patient discusses feelings about elimination pattern. (7,8,9,10)
- Elimination pattern returns to normal. (3,5,6,7,9)
- Patient experiences bowel movement every _____ day(s) without laxatives, enemas, or suppositories. (3,5,6,10,11,12)
- Patient states understanding of factors causing constipation. (1,4,8)
- Patient gets regular exercise. (2)
- Patient describes changes in personal habits to maintain normal elimination pattern. (9,10,11,12)
- Patient states intent to use appropriate resources to help resolve emotional or psychological problems. (9)

Interventions and rationales

1. Correct dietary habits to include adequate fluids, fresh fruits and vegetables, and whole grain cereals and breads, *which supply neces-*

sary bulk for normal elimination.

2. Encourage patient to engage in daily exercise, such as brisk walking, *to strengthen muscle tone and stimulate circulation.*
3. Encourage patient to evacuate at regular times *to aid adaptation and routine physiologic function.*
4. Urge patient to avoid taking laxatives if possible, or to gradually decrease their use, *to avoid further trauma to intestinal mucosa.*
5. Inform patient not to expect a bowel movement every day or even every other day, *to avoid use of poor health practices to stimulate elimination.*
6. If not contraindicated, increase patient's fluid intake to about 3,000 ml daily *to increase functional capacity of bowel elimination.*
7. Explain normal bowel habits *so patient can better understand normal and abnormal body functions.*
8. Reassure patient that normal bowel function is possible without laxatives, enemas, or suppositories *to give patient the necessary confidence for compliance.*
9. Give information about self-help groups, as appropriate, *to provide additional resources for*

patient and family.

10. Establish and implement an individualized bowel regimen based on patient's needs.
11. Instruct patient to avoid straining during elimination *to avoid tissue damage, bleeding, and pain.*
12. Tell patient that abdominal massage may help relieve discomfort and promote defecation *because it triggers bowel's spastic reflex.*

Documentation

- Patient's expressions of concern about change in diet, activity level, laxative and enema use, and bowel pattern
- Observations of diet, stool characteristics, and activity tolerance
- Patient teaching about diet, exercise, and constipation management
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

Definition

Falsely positive self-evaluation based on a self-protective pattern that defends against underlying perceived threats to positive self-regard

Assessment

- Age
- Sex
- Developmental stage
- Family system, including marital status and sibling position
- Reason for hospitalization
- Past experience with illness
- Patient's perception of health problem
- Patient's perception of self, including self-worth, body image, problem-solving ability, and coping mechanisms
- Mental status, including general appearance, affect, mood, cognitive and perceptual functioning, and behavior
- Social interaction pattern

- Support systems, such as family, significant other, and friends

Defining characteristics

- Defensiveness
- Denial of obvious problems
- Difficulty establishing or maintaining relationships
- Difficulty in reality-testing perceptions
- Grandiosity
- Lack of follow-through or participation in treatment or therapy
- Projection of blame or responsibility
- Rationalization of failures

Associated medical diagnoses (selected)

Any illness or injury resulting in chronic pain, permanent disability, or disfigurement. Examples include acquired immunodeficiency syndrome, acute myocardial infarction, alcoholism, anxiety, cancer, drug addiction, end-stage disease (renal, pulmonary, or cardiac)

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient states reason for hospitalization. (1)
- Patient verbally describes self, including concept, body image, successes, failures. (1)
- Patient participates in self-care. (2,3)
- Patient engages in decision-making about treatment. (4)
- Patient accepts responsibility for own behavior. (1,3,6)
- Patient demonstrates follow-through in decisions related to positive health care. (4,6)
- Patient interacts with others in a socially acceptable manner. (5,6)

Interventions and rationales

1. Encourage patient to evaluate self, possibly by making a written list of positive and negative traits of self. *This helps patient identify aspects of self and relate changes to specific variables.*
2. Have patient perform self-care to the extent possible *to provide a sense of control.*
3. Provide a structured daily routine *to provide patient with alternatives to self-absorption.*
4. Help patient make treatment-related decisions and encourage follow-through. *Ability to*

make decisions is principal component of autonomy.

5. Arrange for interaction between patient and others and observe interaction pattern. *Studying patient's verbal and nonverbal interactions with others gives clues to patient's ability to communicate effectively.*

6. Provide positive feedback when patient assumes responsibility for own behavior *to reinforce effective coping behaviors.*

Documentation

- Patient's perception of self
- Behavioral responses
- Social interaction patterns
- Patient's use of defense mechanisms
- Interventions used to facilitate effective coping
- Patient's responses to nursing interventions
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

Definition

Inability to use adaptive behaviors in response to difficult life situations

Assessment

- Family process, including normal pattern of interaction among family members, family's understanding and knowledge of patient's present condition, support systems available (financial, social, spiritual), family's past response to crises (coping patterns), and communication patterns used to express anger, affection, and confrontation
- Patient's illness, including progression and severity of illness, patient's perception of health problem, and problem-solving techniques used by patient to cope with life problems

Defining characteristics

- Family member attempts to describe impact of crisis on personal values, priorities, goals, or relationships.
- Family member moves in direction of health-promoting and enriching life-style that supports and monitors maturational processes and audits and negotiates treatment programs; family member generally chooses experiences that optimize wellness.

Associated medical diagnoses (selected)

Any disorder that results in long-term disability or incapacitation of family member, such as amyotrophic lateral sclerosis, cystic fibrosis, degenerative disease, genetic defects, mental retardation, multiple sclerosis, muscular dystrophy, myelomeningocele, terminal disease, and traumatic injury

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Family discusses impact of patient's illness and feelings about it with health care professional. (1,2,6)
- Family participates in treatment plan. (5)
- Family establishes a visiting routine beneficial to both patient and themselves. (3,6,7)
- Family demonstrates care needed to maintain patient's health status. (4,5,8,9)
- Family identifies and uses available support systems. (2,10)

Interventions and rationales

1. Allow time for family to discuss impact of patient's illness and their feelings. Encourage expression of feelings *to allow family to realistically adjust to patient's problems.*
2. Encourage family conferences; help family members identify key issues and select support services, if needed, *to develop sense of shared responsibility and feelings of safety, adequacy, and comfort.*
3. Help patient and family establish a visiting routine that will not tax patient's or family's resources. Use patient's daily routine to aid in planning—for example, no visiting during treat-

ments or during periods of uninterrupted sleep. *Involving family members reassures patient of their care and reduces family's fear and anxiety.*

4. Reinforce family's efforts to care for patient, *to let them know they are doing their best and to ease adaptation and grieving process.*

5. Demonstrate care procedures and encourage participation in treatment and planning decisions (such as selecting times for pulmonary toilet for patient with cystic fibrosis). *Meeting others' needs promotes self-esteem.*

6. Provide family with clear, concise information about patient's condition. Be aware of what the family has already been told and help them interpret information. *This information will help alleviate their concerns.*

7. Ensure privacy for client and family visits *to foster open communication between them.*

8. Help family support patient's independence. Encourage attendance at therapy sessions and allow patient to demonstrate new skills and abilities. *Independence helps patient reach maximum functional level.*

9. Provide emotional support to family by being available to answer questions. *Attentive*

listening conveys empathy, recognition, and respect for a person.

10. Inform family of community resources and support groups available to assist in managing patient's illness and providing emotional or financial support to the caretakers, such as Easter Seals Association, Visiting Nurse Association, Meals on Wheels. *Community resources may help patient develop potential, independence, and self-reliance.*

Documentation

- Family's response to illness
- Family's current understanding of patient's illness
- Observations about family's interaction with patient and acceptance of current situation
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

Coping, ineffective family: Compromised

related to inadequate or incorrect
information held by primary caregiver

31

Definition

Behavior of family member or others that compromises the patient's and family's capacities to adapt

Assessment

- Family status, including normal pattern of interaction among family members, family's understanding and knowledge of patient's present condition, support systems available (financial, social, spiritual), family's response to past crises, and communication patterns used to express anger, affection, confrontation, conflict
- Patient's illness, including progression and severity of illness, patient's perception of health problem, and problem-solving techniques used by patient to cope with life problems

Defining characteristics

- Patient expresses or confirms concern about family's response to current health problem
- Family member describes or confirms an inadequate understanding or knowledge base that interferes with effective assistive or supportive behaviors
- Family member displays protective behavior disproportionate to patient's abilities or need for autonomy

Associated medical diagnoses (selected)

Any disorder that results in long-term disability or incapacitation, such as degenerative and terminal disorders and traumatic injuries

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Family discusses impact of patient's illness and feelings about it with health care professional. (2,5)
- Family designates a spokesperson to receive information regarding the patient's illness. (1)
- Family establishes a visiting routine beneficial to both patient and family. (3,4,5,6)
- Family states understanding of patient's health status. (7,8)
- Family identifies and uses available support systems. (2,4)

Interventions and rationales

1. Identify the spokesperson for the family to avoid creating communication conflicts within family.
2. Facilitate family conferences; help family members identify key issues and select support services, if needed. *Involving patient and family in care planning promotes open communication throughout the illness.*
3. Help patient and family establish a visiting routine that will not tax their resources. Each family member may take a day or period of time, if desired. Use patient's daily routine to

aid in planning; for example, no visiting during treatments or periods of uninterrupted sleep.

This enhances family's sense of contributing to patient's overall care.

4. Encourage family to contact a community agency for continued support, if necessary.

This is an effective health-related coping skill.

5. Provide family with clear, concise information about patient's condition. Be aware of what family has already been told and help them interpret information. *This ensures clear, uncluttered communication between patient, family, and caregivers.*

6. Ensure privacy for patient and family visits. *This demonstrates respect and fosters open communication between family members.*

7. Help family support the patient's independence. Encourage attendance at therapy sessions and allow patient to demonstrate new skills and abilities to help family members learn how they can help promote patient's independence and self-care.

8. Provide emotional support to family by being available to answer questions. *This demonstrates your willingness to help family seek health-related information.*

Documentation

- Family's response to illness
- Family's current understanding of patient's illness
- Observations about family's interaction with patient and acceptance of current situation
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

Coping, ineffective family: Disabling related to unresolved emotional conflict between patient and family members

32

Definition

Behavior of family members that undermines the patient's and family's ability to adapt

Assessment

- Patient's illness, including its course, severity, and effect on family members
- Patient's health care resources, including hospital, community resources, health care providers such as therapists, case manager
- Demands on family imposed by the patient's condition
- Family status, including involvement with patient, quality of relationships, communication patterns, coping strategies, family's understanding of patient's illness, feelings about patient's illness, willingness of family members to commit time to patient care, family's ability to provide care

Defining characteristics

- Family members are intolerant of the patient's physical ailments or psychological weaknesses
- Family members disregard patient's basic human needs
- Family members exhibit distorted perceptions of the patient's health problem, including extreme denial about its existence or severity
- Family members refuse to participate in care of the patient
- Patient develops helpless, dependent attitude and experiences corresponding decrease in activity level
- Patient experiences psychosomatic symptoms
- Patient expresses feelings of abandonment, agitation, depression, aggression, rejection, and hostility
- Patient reports poor relationships with family members

Associated medical diagnoses (selected)

Any disorder that results in long-term disability or incapacitation, such as degenerative and terminal disorders and traumatic injuries

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- To the extent possible, family members participate in aspects of patient's care without evidence of increased conflict. (1,2)
- Patient expresses confidence in his ability to make decisions, despite pressure from family members. (3)
- Patient contacts appropriate sources of support outside the family. (4)
- Patient takes steps to ensure that care needs are met despite family's shortcomings. (5)
- Patient expresses greater understanding of the emotional limitations of family members. (6)

Interventions and rationales

1. Assess the effects of the patient's disease on family functioning *to plan interventions*. To the extent possible, encourage family members to participate in patient care. *Family members should have an opportunity to overcome dysfunctional behavior.*
2. Maintain objectivity when dealing with family conflicts. Do not become embroiled in the dynamics of a dysfunctional family *to uphold your ability to intervene effectively.*

3. If the patient and family members appear incapable of taking steps to heal their relationships, focus on being a patient advocate. Reaffirm the patient's right to make his own decisions without interference from family members. Provide necessary information to the patient to facilitate decision-making. *Dysfunctional family coping patterns evolve over many years, and are unlikely to change just because the patient has a serious illness. Accepting your limitations when working with family members will help you to avoid burnout and better meet the patient's needs.*
4. Encourage the patient to seek the emotional support his family is unable to provide through participating in a support group. Help the patient select the support group that is best suited to his personal needs and outlook. Consider recommending Co-Dependents Anonymous, a group for individuals who have difficulty maintaining healthy relationships as a result of being raised in a dysfunctional family. *Participation in a support group may provide an opportunity to form meaningful relationships.*
5. Refer the patient to a home health agency,

homemaker service, Meals On Wheels, or other appropriate outside agencies for assistance and follow-up. *Use of various community services may help to make up for shortcomings in the family's ability to provide care.*

6. Listen openly to the patient's expressions of pain over unresolved conflicts with family members. The patient may have to grieve over the fact that he will never have an "ideal" family, capable of fully meeting his emotional needs. *Therapeutic listening helps the patient to understand himself and his family better and to understand how conflicts from the past affect his behavior.*

Documentation

- Family's response to patient's illness
- Observations of patient's interactions with family members
- Referrals made to support groups and community services
- Patient's expressions of grief, anger, disappointment over unresolved conflicts with family members
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

Definition

Inability to use adaptive behaviors in response to such difficult life situations as loss of health, a loved one, or job

Assessment

- Coping behaviors
- Degree of physical and emotional impairment
- Diversional activities
- Financial resources
- Occupation
- Patient's perception of present health problem or crisis
- Problem-solving techniques usually employed to cope with life problems
- Support systems, including family, companion, friends, and clergy

Defining characteristics

- Change in usual communication patterns
- Chronic fatigue
- Chronic worry
- Evidence or verification of situational crisis
- Excessive drinking
- Inability to meet role expectations, meet basic needs, or solve problems
- Inappropriate use of defense mechanisms
- Insomnia
- Irritability
- Irritable bowel
- Muscular tension
- Overeating or lack of appetite
- Verbal manipulation
- Verbal expression of inability to cope or ask for help

Associated medical diagnoses (selected)

Acute myocardial infarction, alcoholism, bipolar disease (mania and depression), cancer, depression, drug addiction or overdose, drug withdrawal, end-stage disease (renal, pulmonary, or cardiac), self-inflicted injuries, trauma

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient communicates feelings about the present situation. (1,2,3)
- Patient becomes involved in planning own care. (6,7,8)
- Patient expresses feeling of having greater control over present situation. (4,5,6,7,8,12)
- Patient uses available support systems, such as family and friends, to aid in coping. (9)
- Patient identifies at least two coping behaviors. (10,11)
- Patient demonstrates ability to use two healthful coping behaviors. (12,13)

Interventions and rationales

1. If possible, assign a primary nurse to patient *to provide continuity of care and promote development of therapeutic relationship.*

2. Arrange to spend uninterrupted periods of time with patient. Encourage expression of feelings and accept what patient says. Try to identify factors that cause or exacerbate patient's inability to cope, such as fear of loss of health or job. *Devoting time for listening helps patient express emotions, grasp situation, and cope effectively.*

3. Identify and reduce unnecessary stimuli in environment *to avoid subjecting patient to sensory or perceptual overload.*
4. Initially, allow patient to depend partly on you for self-care. *Patient may regress to a lower developmental level during initial crisis phase.*
5. Explain all treatments and procedures and answer patient's questions *to allay fear and allow patient to regain sense of control.*
6. Encourage patient to make decisions about care *to increase sense of self-worth and mastery over current situation.*
7. Have patient increase self-care performance levels gradually, *which allows progress at patient's own pace.*
8. Praise patient for making decisions and performing activities *to reinforce coping behaviors.*
9. Encourage patient to use support systems to assist with coping, *thereby helping restore psychological equilibrium and prevent crisis.*
10. Help patient look at current situation and evaluate various coping behaviors *to encourage a realistic view of crisis.*
11. Encourage patient to try coping behaviors.

A patient in crisis tends to accept interventions and develop new coping behaviors more easily than at other times.

12. Request feedback from patient about behaviors that seem to work *to encourage patient to evaluate the effect of these behaviors.*
13. Refer patient for professional psychological counseling. *If patient's maladaptive behavior has high crisis potential, formal counseling helps ease nurse's frustration, increases objectivity, and fosters collaborative approach to patient's care.*

Documentation

- Patient's perception of present situation and what it means
- Patient's verbal expression of feelings indicating comfort or discomfort
- Observations of patient's behaviors
- Interventions to help patient cope
- Patient's responses to interventions
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

Decisional conflict related to initiating or withholding life-sustaining treatment

34

Definition

State of moral uncertainty about initiating, continuing, or withholding life support in a terminally ill patient near death

Assessment

- Patient's age
- Patient's health status, including sensation, reflexes, peripheral circulation, sight, hearing, body temperature, consciousness, likelihood of survival, likelihood of permanent brain damage, need for life-sustaining or life-saving intervention (cardiopulmonary resuscitation, mechanical breathing, artificial nutrition and hydration, major surgery, dialysis, chemotherapy, invasive diagnostic tests, transfusions, antibiotics, analgesics)
- Spiritual values, including the patient's and family's religious affiliation, beliefs about sanctity of life, requests for consultation with minister, priest, or rabbi
- Sociocultural factors, including the patient's

and family's educational levels, socioeconomic status, ethnic identity

- Family status, including level of functioning (cognitive, emotional, behavioral), coping mechanisms, past experience with decision making, available support systems
- Patient's expressed wishes regarding life-sustaining treatment, including existence of living will or durable power of attorney, other advance directives, verbal or written requests to stop resuscitation efforts

Defining characteristics

- Patient is comatose or in a persistent vegetative state with little or no likelihood of recovery
- Patient is in terminal stage of illness
- Patient has lost the ability to communicate his desires about medical care
- Family members report severe emotional distress over whether to initiate, continue, or withhold life-sustaining treatment for patient

- Family members express doubt in personal values and beliefs while attempting to reach a decision

Associated medical diagnoses (selected)

This nursing diagnosis is associated with coma, persistent vegetative states, or terminal stage of illness where the patient has no likelihood of survival or little hope of regaining awareness and higher mental functions

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Family members express feelings about decision confronting them. (1,2)
- Family members express conflict between personal beliefs and the option of withdrawing life-sustaining treatment. (1,2,6,7)
- Family members express understanding of treatment options. (3,4)
- Family members express understanding of the purpose of the patient's living will or other advance directive. (5)
- Family members accept assistance from clergy and other supportive persons. (8)

Interventions and rationales

1. Provide a quiet environment to meet with family members to discuss patient's condition and treatment options. Do not rush them. Keep all communication factual and direct. Express medical information in clear, simple language. *Effective communication is essential when helping families to decide whether to initiate or withhold treatment.*
2. Acknowledge family members' values and beliefs; be open to all expression of ethical, moral, and religious conflict. *You must be*

open to values and beliefs different from your own to provide effective guidance for family members.

3. Help family members identify full range of options regarding medical treatment and the possible consequences *to encourage thoughtful consideration of treatment options.*

4. If appropriate, explain to family members that limiting treatment doesn't mean abandoning the patient. The patient will still receive care to preserve comfort, hygiene, and dignity as well as adequate pain control. *Family members may find it easier to come to terms with their decision to limit treatment if assured that the patient is not being abandoned.*

5. If the patient has signed an advance directive, such as a living will, explain the significance of this document to family members. If family members dispute the advance directive, follow institutional procedure for addressing such a conflict. If appropriate, refer the case to an ethics committee. *In many cases, the nurse is the first to recognize conflicts between family members over a living will.*

6. If the patient is terminally ill, help family members begin the task of mourning *so that*

they will be able to cope with the eventual loss.

7. Be alert for expressions of guilt over decision to withhold or initiate treatment. Explain that no easy answers exist and that family members can only do what they believe is right. *Providing support after decision-making will help family members resolve feelings of guilt, anger, and depression.*

8. Refer family members to support group or clergyperson as appropriate *to help them find continued support for accepting their decision.*

Documentation

- Assessment of family's value system
- Family members' requests for consultation with spiritual support person
- Family members' expressions of moral, religious, and emotional conflict
- Presence of living will or other advance directive
- Interventions to assist family members with decision-making process
- Family's response to nursing interventions
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

Definition

State of uncertainty about health-related course of action when choice involves risk, loss, or challenge to personal life values

Assessment

- Perception of situation representing conflict
- Age
- Sex
- Developmental state
- Marital status
- Family system (nuclear, extended role, sibling position)
- Sociocultural factors, including educational level, occupation, socioeconomic status, ethnic group, sexual preference
- Level of functioning (cognitive, emotional, behavioral)
- Coping mechanisms
- Past experience with decision making
- Available support system

Defining characteristics

- Delayed decision making
- Physical signs of distress or tension
- Questioning personal values and beliefs while attempting to make a decision
- Vacillation between alternative choices
- Verbal report of distress related to uncertainty about choices
- Verbal report of undesired consequences of alternative actions being considered

Associated medical diagnoses (selected)

This nursing diagnosis can occur in any hospitalized patient confronted with choices related to life-sustaining or life-saving measures. Examples include any illness requiring patient's choice between palliative comfort measures, discontinuation of life-support, or cardiopulmonary resuscitation; cancers requiring radiation or chemotherapy; conditions requiring amputation of an extremity; end-stage cardiac disease requiring artificial or human heart transplant; end-stage renal disease requiring chronic hemodialysis or kidney transplant

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient states feelings about current situation. (1,2)
- Patient discusses concerns about potential conflict between value system and treatment options. (1,2)
- Patient identifies desirable and undesirable consequences of available options. (3)
- Patient makes minor decisions related to daily activities. (4)
- Patient accepts assistance from family, friends, clergy, and other supportive persons. (5,7)
- Patient reports feeling comfortable about ability to make an appropriate, rational choice congruent with personal values. (6)

Interventions and rationales

1. Visit patient frequently, taking a nonjudgmental approach to encourage expression of feelings. *This demonstrates acceptance of patient as person of worth regardless of culture, beliefs or value system.*
2. Acknowledge patient's values and beliefs; be willing to listen to patient's concerns regarding current dilemma. *Nurse must lay aside*

own values to enter patient's world without prejudice.

3. Help patient identify available options and their possible consequences. *This encourages thoughtful consideration of consequences of each choice and relies on patient's cognitive abilities.*

4. Help patient make decisions about daily activities. *Ability to make decisions is principal component of autonomy.*

5. Encourage visits with family, significant others, clergy; provide privacy during visits. *If emotional support system is less available, event will be more hazardous.*

6. Demonstrate respect for patient's right to choose based on values, religious beliefs, cultural norms, or sexual preference. *Respect is demonstrated by nurse's unconditionally positive regard for patient's value system.*

7. Encourage patient's continued use of religious practices or rituals while in the hospital; provide assistance when possible. *This demonstrates acceptance, caring and support.*

Documentation

- Assessment factors related to patient's value system
- Patient's feelings and concerns about current situation
- Cognitive, emotional, and behavioral levels of functioning
- Interventions to assist patient with conflict resolution
- Patient's response to nursing interventions
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

Definition

Conscious or unconscious attempt to disavow the knowledge or meaning of an event to reduce anxiety or fear to the detriment of health

Assessment

- Perception of present health state, including awareness of diagnosis, perception of personal relevance or impact on life pattern, and description of symptoms
- Degree of physical and emotional functional impairment
- Mental status, including general appearance, affect, mood, memory, orientation, communication, thinking process, perception, abstract thinking, judgment, and insight
- Coping behaviors
- Problem-solving strategies
- Support systems, including family or significant other, friends, clergy, and financial resources

- Belief system, including values, norms, and religion
- Self-concept, including self-esteem and body image

Defining characteristics

- Cannot admit impact of disease on life pattern
- Delays seeking or refuses medical attention to detriment of health
- Displaces fear of condition's impact
- Displaces sources of symptoms to other organs
- Displays inappropriate affect
- Does not admit fear of death or invalidism
- Does not perceive personal relevance of symptoms or danger
- Minimizes symptoms
- Uses self-treatment to relieve symptoms

Associated medical diagnoses (selected)

Acquired immunodeficiency syndrome, acute myocardial infarction, alcoholism, anxiety, bipolar disease (manic or depressive phase), cancer, depression, end-stage disease (renal, pulmonary, or cardiac), self-destructive behaviors (anorexia nervosa, bulimia, drug addiction)

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient describes knowledge and perception of present health problem. (1,2,3,4)
- Patient describes life pattern and reports any recent changes. (1,2,4)
- Patient expresses knowledge of stages of grief. (5)
- Patient demonstrates behavior associated with grief process. (2,5,7)
- Patient discusses present health problem with physician, nurses, and family or significant other. (6)
- Patient indicates by conversation or behavior an increase in reality-testing. (7)

Interventions and rationales

1. Provide for a specific amount of uninterrupted non-care-related time with patient each day. *This allows patient to ventilate knowledge, feelings, and concerns.*
2. Encourage patient to express feelings related to present problem, its severity, and its potential impact on life pattern. *This helps patient express doubts and resolve concerns.*
3. Maintain frequent communication with doctor to assess what patient has been told about

illness. *This fosters consistent, collaborative approach to patient's care.*

4. Listen to patient with nonjudgmental acceptance, *to demonstrate positive regard for patient as person worthy of respect.*
5. Help patient learn the stages of anticipatory grieving, *to increase understanding and ability to cope.*
6. Encourage patient to communicate with others, asking questions and clarifying concerns based on readiness. *Patient fixated in denial may isolate and withdraw from others.*
7. Visit more frequently as patient begins to accept reality; alleviate fears when necessary. *This helps reduce patient's fear of being alone and fosters accurate reality testing.*

Documentation

- Patient's perception of health problem
- Mental status (baseline and ongoing)
- Patient's knowledge of grief process
- Patient's behavioral responses
- Interventions implemented to assist patient
- Patient's response to nursing interventions
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

related to malabsorption,
inflammation, or irritation of bowel

Definition

Interruption of normal elimination pattern characterized by frequent, loose stools

Assessment

- History of bowel disorder or surgery
- Gastrointestinal status, including nausea and vomiting, usual bowel habits, change in bowel habits, stool characteristics (color, amount, size, consistency), pain, inspection of abdomen, auscultation of bowel sounds, palpation for masses and tenderness, percussion for tympany and dullness, laxative and enema use, medications (especially antibiotics), stool culture, upper GI series, barium enema
- Nutritional status, including dietary intake, change from normal diet, appetite, current weight, change from normal weight, and food irritants and contaminants
- Fluid and electrolyte status, including intake and output, urine specific gravity, skin turgor, mucous membranes, serum potassium and

sodium, and blood urea nitrogen

- Psychosocial status, including personality, stressors (finances, job, marital discord, disease process), coping mechanisms, support systems, life-style, and recent travel

Defining characteristics

- Abdominal pain and cramping
- Clinical evidence of malabsorption, inflammation, or irritation of bowel
- Hyperactive bowel sounds
- Increased frequency of stool
- Loose, liquid stools; possibly bloody, mucoid, fatty, or bulky
- Stool color changes
- Urgency

Associated medical diagnoses (selected)

Amebiasis, *Campylobacter* dysentery, Crohn's disease, diverticulitis, drug-induced diarrhea, irritable bowel syndrome, ischemic colitis, lactase deficiency, pseudomembranous colitis, salmonellosis, shigella, trichinosis, typhoid fever, ulcerative colitis

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient controls diarrhea with medication. (1,2,3,4)
- Elimination pattern returns to normal. (1,4,6)
- Patient regains and maintains fluid and electrolyte balance. (3,4,5)
- Skin remains intact. (5,7)
- Patient discusses causative factors, preventive measures, and changed body image. (7,12)
- Patient practices stress-reduction techniques daily. (8)
- Patient demonstrates skill in using ostomy devices. (9,10,11)
- Patient seeks out persons with similar conditions or joins a support group. (13)

Interventions and rationales

1. Monitor frequency and characteristics of stool; auscultate bowel sounds and record results at least every shift *to monitor treatment effectiveness.*
2. Tell patient to notify staff of each episode of diarrhea *to promote comfort and maintain communication.*
3. Give antidiarrheal medications, as ordered, *to improve bodily function, promote comfort,*

and balance body fluids, salts, and acid-base levels. Monitor and report efficacy. ‡

4. Monitor and record patient's intake and output, including number of stools. Report imbalances. *Monitoring ensures correct fluid replacement therapy.*

5. Check skin daily *to detect and prevent breakdown.* Report decreased skin turgor or excoriation of perianal area.

6. Weigh patient daily until diarrhea is controlled *to detect fluid loss or retention.*

7. Teach patient about:

- a. causative and preventive factors *to promote understanding of problem.*

- b. how to cleanse perianal area, including use of powders and lotions, *to promote comfort and skin integrity.*

- c. dietary restriction to control diarrhea, such as a lactose-free diet, *which reduces residual waste and decreases intestinal irritation and spasms.*

8. Teach stress-reduction techniques and help the patient perform them daily by providing time, privacy, and needed equipment. *This temporarily relieves emotional distress.*

9. Prepare patient for surgery and provide pre-

operative instruction for abdominal surgery *to reassure patient and maintain trust.* Provide information about ileostomy or colostomy, if indicated, *to help patient understand procedure and avoid threat to health equilibrium.*

10. Demonstrate use of ostomy equipment *to encourage understanding and compliance.*

11. Provide support and assistance while patient develops skill in caring for stoma, *to improve understanding and reduce anxiety.*

12. Encourage expression of feelings and concerns about impact of changed body image *to allow patient to pinpoint specific fears and promote self-knowledge and growth.*

13. Encourage use of support groups, such as ileostomy clubs, *to provide patient with additional support and health care resources.*

Documentation

- Patient's expressions of concern about diarrhea, causative factors, surgery, and adaptation to changes in body image
- Observations of effects of medications, intake and output, weight, stool characteristics, skin condition, and stoma appearance
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Definition

Interruption of normal bowel movements resulting in frequent, loose stools

Assessment

- History of bowel disorder or surgery
- Gastrointestinal status, including nausea and vomiting, usual bowel habits, change in bowel habits, stool characteristics (color, amount, size, consistency), pain and discomfort, inspection of abdomen, auscultation of bowel sounds, palpation for masses and tenderness, percussion for tympany and dullness
- Nutritional status, including dietary intake, change from normal diet, appetite, current weight, change from normal weight
- Fluid and electrolyte status, including intake and output, urine specific gravity, skin turgor, mucous membranes, serum K^+ , serum Na^+ , and blood urea nitrogen

- Psychosocial status, including personality, stressors (finances, job, marital discord), coping mechanisms, support systems (family, significant other, life-style)

Defining characteristics

- Abdominal pain and cramping
- Changes in stool color
- Increased frequency of stool
- Loose, liquid stools
- Urgency
- Verbal expression of stress or anxiety

Associated medical diagnoses (selected)

Anxiety, irritable bowel syndrome (spastic colon, ulcerative colitis, mucous colitis)

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Diarrheal episodes decline or disappear. (2)
- Usual bowel pattern resumes. (1,2,3)
- Patient regains and maintains fluid and electrolyte balance. (3)
- Patient keeps skin clean and free of irritation or ulcerations. (4)
- Patient explains causative factors and preventive measures. (5,6,7,8,9)
- Patient discusses relationship of stress and anxiety to episodes of diarrhea. (5,6,7,8,9)
- Patient states plans to utilize stress-reduction techniques (specify). (8,9)
- Patient demonstrates ability to use at least one stress-reduction technique. (7,8,9)

Interventions and rationales

1. Monitor and record frequency and characteristics of stool *to monitor treatment effectiveness*. Instruct patient to record diarrheal episodes and report them to staff *to promote comfort and maintain effective patient-staff communication*.
2. Administer antidiarrheal medications, as ordered, *to improve bodily function, promote comfort, and balance body fluids, salts, and*

acid-base levels. Monitor and report medications' effectiveness. ‡

3. Provide replacement fluids and electrolytes, as prescribed. Maintain accurate records *to ensure balanced fluid intake and output*. ‡
4. Monitor perianal skin for irritation and ulceration; treat according to established protocol *to promote comfort, skin integrity, and freedom from infection*.
5. Identify stressors and help patient solve problems *to provide more realistic approach to care*.
6. Encourage patient to ventilate stresses and anxiety; *release of pent-up emotions can temporarily relieve emotional distress*.
7. Teach patient to:
 - a. use relaxation techniques *to reduce muscle tension and nervousness*.
 - b. recognize and reduce intake of diarrhea-producing foods or substances (such as dairy products, fruit), *thus reducing residual waste matter and decreasing intestinal irritation*.
8. Spend at least 10 minutes with patient twice daily to discuss stress-reducing tech-

niques; *this can help patient pinpoint specific fears*.

9. Encourage and assist patient to practice relaxation techniques *to reduce tension and promote self-knowledge and growth*.

Documentation

- Patient's expressions of concern and ability to manage diarrhea produced by stress and anxiety
- Observations of effects of relaxation and stress-reduction techniques and dietary management on diarrhea
- Patient's responses and skill level in carrying out stress-reduction techniques and dietary changes
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Definition

State of being at risk for deterioration of body systems as a result of prescribed or unavoidable inactivity

Assessment

- Condition leading to prolonged inactivity or immobility
- Age
- Neurologic status, including mental status, level of consciousness, sensory and motor ability
- Cardiovascular status, including blood pressure, heart rate, temperature, peripheral pulses, capillary refill, clotting profile, skin temperature and color, presence of edema, chest pain or discomfort
- Respiratory status, including rate and rhythm, depth of inspiration, chest symmetry, use of accessory muscles, cough and sputum, percussion of lung fields, auscultation of

breath sounds, chest pain or discomfort, arterial blood gases

- Gastrointestinal status, including inspection of abdomen, auscultation of bowel sounds, palpation for tenderness and masses, percussion for areas of dullness, usual bowel habits, change in bowel habits, laxative use, pain or discomfort, characteristics of stool (color, size, amount, consistency)
- Nutritional status, including dietary intake, appetite, current weight, change from normal weight
- Fluid status, including intake and output, urine specific gravity, mucous membranes, serum electrolytes, blood urea nitrogen, creatinine
- Genitourinary status, including voiding pattern, characteristics of urine (color, odor, sediment, amount), history of urinary problems or infections, palpation of bladder, pain or discomfort, use of urinary assistive device, urinalysis and urine cultures

- Musculoskeletal status, including range of motion; muscle size, strength, and tone; coordination; and functional mobility scale:

- 0 = completely independent
- 1 = requires use of equipment or device
- 2 = requires help, supervision, or teaching from another person
- 3 = requires help from another person and equipment or device
- 4 = dependent; does not participate in activity

- Integumentary status, including color, texture, turgor, temperature, elasticity, sensation, moisture, hygiene, lesions
- Psychosocial factors, including family support, coping style, current understanding of prescribed inactivity, willingness to cooperate with treatment, mood, behavior, motivation, and stressors (inactivity, finances, job, marital discord)

Risk factors

- Level of consciousness altered
- Mechanical immobilization
- Paralysis
- Prescribed immobilization
- Severe pain

Associated medical diagnoses (selected)

This diagnosis may occur in any patient subject to prescribed or unavoidable inactivity. Examples include cerebrovascular accident, fractures (with traction or cast), neuromuscular disorders, peripheral vascular disease, rheumatoid arthritis, severe head injury, spinal cord injury, terminal cancer

Expected outcomes [†]

- Patient displays no evidence of altered mental, sensory, or motor ability. (1,2)
- Patient has no evidence of thrombus formation, venous stasis, or altered cardiovascular function. (2,5,6,10,17)
- Patient shows no evidence of decreased chest movement, cough stimulus, or depth of ventilation; also shows no pooling of secre-

tions or signs and symptoms of infection. (2,8,10,11)

- Patient has no evidence of constipation and maintains bowel patterns. (12,13)
- Patient maintains adequate dietary intake, hydration, and weight. (9,14)
- Patient shows no evidence of urine retention, infection, or renal calculi. (9,12,15)
- Patient maintains muscle strength and tone; also joint range of motion; shows no evidence of contractures. (17)
- Patient shows no evidence of skin breakdown. (3)
- Patient maintains normal neurologic, cardiovascular, respiratory, gastrointestinal, nutritional, genitourinary, musculoskeletal, and integumentary functioning during period of inactivity. (1-18)
- Patient states feelings about prescribed or unavoidable inactivity. (19)

Interventions and rationales

1. Provide frequent contact with staff, diversionary materials (magazines, radio, TV), and orienting mechanisms (clock, calendar). *Real-*

ity orientation fosters patient awareness of environment.

2. Avoid positions that put prolonged pressure on body parts and compress blood vessels. Patient should change positions at least every 2 hours within prescribed limits. *These measures enhance circulation and avoid tissue or skin breakdown.*

3. Inspect skin every shift and protect areas subject to irritation. Follow hospital policy for pressure ulcers *to prevent or mitigate skin breakdown.*

4. Use pressure-reducing or -equalizing equipment as indicated or ordered (floatation pad, air pressure mattress, sheepskin pads, special bed). *This helps prevent skin breakdown by relieving pressure.* [‡]

5. Apply elastic stockings; remove for 1 hour every 8 hours. *Stockings promote venous return to heart, prevent venous stasis, and decrease or prevent swelling of lower extremities.* [‡]

6. Monitor clotting profile. Administer and monitor anticoagulant therapy, if ordered, and monitor for signs and symptoms of bleeding

(continued)

[†] Numbers following outcomes refer to interventions.

[‡] Indicates doctor-ordered instruction.

Interventions and rationales (continued)

because anticoagulant therapy may cause hemorrhage. ‡

7. Monitor temperature, blood pressure, pulse, and respirations at least every 4 hours *to assess for signs and symptoms of infection or other complications.*

8. Teach and monitor deep-breathing, coughing, and use of incentive spirometer. Maintain regimen every 2 hours. *These measures help clear airways, expand lungs, and prevent respiratory complications.*

9. Encourage fluid intake of 2,500 to 3,500 ml daily, unless contraindicated, *to maintain urinary output and aid bowel elimination.* Weigh daily and monitor hydration status (serum electrolytes, blood urea nitrogen, creatinine, and intake and output every 8 hours).

10. Monitor breath sounds, respiratory rate, rhythm, and depth at least every 4 hours *to rule out respiratory complications.* Monitor arterial blood gases, if indicated, *to assess*

oxygenation, ventilation, and metabolic status.

11. Suction airway as needed and ordered *to clear the airway and stimulate cough reflex;* note secretion characteristics.

12. Establish baseline *to compare elimination patterns and habits.* Elevate head of bed and provide privacy *to allow comfortable elimination.*

13. Instruct patient to avoid straining during bowel movements; administer stool softeners, suppositories, or laxatives as ordered and monitor effectiveness. *Straining at stool may be hazardous in patients with cardiovascular disorders and increased intracranial pressure.*

14. Provide small, frequent meals of favorite foods *to increase dietary intake.* Increase fiber content *to enhance bowel elimination.* Increase protein and vitamin C *to promote wound healing.* Limit calcium *to reduce risk of renal and bladder calculi.*

15. Monitor urine characteristics and patient's subjective complaints typical of urinary tract

infection (burning, frequency, urgency). Obtain urine cultures as ordered. *These measures aid early detection of urinary tract infection. ‡*

16. Identify level of functioning *to provide baseline for future assessment* and encourage appropriate participation in care *to prevent complications of immobility and increase patient's feelings of self-esteem.*

17. Perform active or passive range-of-motion exercises at least once per shift. Teach and monitor appropriate isotonic and isometric exercises. *These measures prevent joint contractures, muscular atrophy, and other complications of prolonged inactivity.*

18. Provide or help with daily hygiene; keep skin dry and lubricated *to prevent cracking and possible infection.*

19. Allow patient and family or significant other to ventilate frustration and other feelings related to prolonged inactivity. *Expressing feelings helps patient and family or significant other cope with treatment regimen.*

‡ Indicates doctor-ordered instruction.

Documentation

- Patient's concerns or perceptions of circumstances necessitating inactivity; willingness to accept and participate in treatment
- Assessment of body systems at risk for deterioration
- Interventions to provide preventive or supportive care and prescribed treatment
- Treatment given to patient; patient's understanding and demonstrated ability to carry out instructions
- Patient's response to nursing interventions
- Evaluations for each expected outcome.

Care plan notes

Definition

Restriction or decline in ability to use unoccupied time to patient's advantage or satisfaction

Assessment

- Physical status, including mobility and activity tolerance
- Cardiovascular status
- Respiratory status
- Neurologic status, including level of consciousness, orientation, mood, behavior, memory
- Psychosocial status, including family or friends, hobbies, interests, favorite music, TV, reading matter, changes or adaptations needed to carry out activities

Defining characteristics

- Evidence of environmental deprivation
- Physical limitations affecting participation in usual activities
- Statement of boredom or wishing for something to do

Associated medical diagnoses (selected)

Any patient hospitalized for a prolonged period may be at risk. Additional diagnoses include: blindness, conditions requiring isolation or intensive care, depression, detached retina, fractures requiring skeletal traction, and hearing loss.

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient expresses interest in using leisure time meaningfully. (1,2,3,4,5,6,7,8)
- Patient expresses interest in activities provided. (4,10,12)
- Patient participates in chosen activity. (5,6)
- Patient watches selected TV program or listens to selected music daily. (2,13)
- Patient reports satisfaction with use of leisure time. (3,4,10,11,12)
- Patient or caregiver modifies environment to provide maximum stimulation, such as with posters or cards or moving bed next to a window. (9,11,12)

Interventions and rationales

1. Encourage discussion of previously enjoyed hobbies, interests, or skills *to direct planning of new activities*. Suggest performing an activity helpful to others or otherwise productive.
2. Obtain radio or TV (if desired) and allow patient to select programs. Communicate patient's desires to co-workers. Turn on TV set at _____ (time) to _____ (channel). *Selective TV or radio use can help pass time.*
3. Ask volunteers (friends, family, or hospital

- volunteer) to read newspapers, books, or magazines to patient at specific times. *Personal contacts helps alleviate boredom.*
4. Engage patient in conversation while carrying out routine care. Discuss patient's favorite topics as much as possible. *Conversation conveys caring and recognition of patient's worth.*
 5. Provide supplies and set time to carry out hobby; for example, give crochet hook and yarn to patient daily at _____ (time). *Specifying time for activity indicates its value.*
 6. Avoid scheduling procedures during patient's leisure time, *which is integral to quality of life.*
 7. Provide talking books or records if available. *These provide low-effort sources of enjoyment for bedridden patient.*
 8. Obtain an adapter for the TV *to provide captions for hearing-impaired patient.*
 9. Encourage patient's family or caregiver to bring in personal articles (posters, cards, pictures) to help make environment more stimulating. *Patient may respond better to objects with personal meaning.*
 10. Make referral to recreational, occupational, or physical therapist for consultation on adap-

- tive equipment to carry out desired activity; arrange for therapy sessions. *Adaptive equipment allows patient to continue enjoying activities or may stimulate interest in new activities.*
11. Provide plants for patient to tend. *Caring for live plants may stimulate interest.*
 12. Change scenery when possible; for example, place patient's bed in hall for a short period or take patient outside in wheelchair *to help reduce boredom.*
 13. Identify type of music patient prefers; get help from family and hospital resources to provide selected music daily. *Music may relieve boredom.*

Documentation

- Patient's expression of boredom, frustration, and desire to carry out leisure activity
- Patient's interests and ability to carry out activity and necessary modifications required to accomplish activity
- Observations of patient's skill level and extent of participation in activity
- Patient's expression of satisfaction with use of unoccupied time
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

Diversional activity deficit
related to long-term hospitalization
or frequent, lengthy treatments

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Definition

Restriction or decrease in ability to use unoccupied time to one's advantage or satisfaction

Assessment

- Physical status, including mobility and activity tolerance
- Cardiovascular status
- Respiratory status
- Neurologic status, including level of consciousness, orientation, mood, behavior, memory
- Psychosocial status, including family or significant other, hobbies, interests, favorite music, TV, reading matter, changes or adaptations needed to carry out activities

Defining characteristics

- Hospital stay beyond acute stage of illness
- Physical limitations affecting participation in usual activities
- Statement of boredom or wishing for something to do
- Treatments performed more than once a day or that require significant amounts of time

Associated medical diagnoses (selected)

Any patient hospitalized for a lengthy period of time may be at risk for this diagnosis. Examples include: burns, pressure ulcers, isolation for contagious diseases, multiple fractures, peripheral vascular ulcers, plastic surgery involving extensive skin grafting, spinal cord injury

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient expresses interest in using leisure time meaningfully. (1,2,3,4,5,6,7)
- Patient participates in chosen activity. (1,2,4)
- Patient states satisfaction with use of leisure time. (3,4,6)
- Patient expresses interest in activities provided. (5,8)
- Patient makes decisions about timing and spacing of treatments. (9)
- Patient expresses satisfaction with established schedule of treatment routines. (9,10)

Interventions and rationales

1. Schedule time daily to pursue leisure activities; for example, have patient sit at desk daily in wheelchair to use paint-by-number kit. *Diversional activities improve patient's quality of life; scheduling activities indicates their value.*

2. Encourage family or significant other to bring in familiar objects. Provide space for favorite plants, cards, reading material, and hobby supplies. For bedridden clients, use ceiling for posters and other objects. *Maintaining personal contacts and involvement relieves boredom and stimulates interest.*

3. Encourage patient to express enjoyment of past hobbies, interests, or skills. *This conveys a sense of worth and caring, and helps patient to think of new activities.*

4. Work with patient and family to find ways to carry out desired activities. Use imagination and creativity; for example, a former carpenter may adapt to carving small objects rather than building large ones. *Adaptive equipment helps patient pursue previous activities within new limits.*

5. Provide radio or TV at patient's request to help relieve boredom and increase enjoyment.

6. Engage patient in conversation while carrying out procedures, if desired by patient. Discuss favorite topics. *Conversation during treatments reduces discomfort by diverting attention; it also increases patient's sense of self-worth.*

7. Encourage visitors to involve patient in favorite activities through discussion, reading, and attendance at programs, if appropriate, to reduce boredom.

8. Keep patient informed of current events through discussion; encourage patient to read newspapers or books and watch TV or listen

to radio. *Keeping current helps reduce the isolation of long-term hospitalization.*

9. Schedule treatments to allow adequate rest periods and pursuit of favorite activity; for example, no treatments between _____ and _____ (time), to allow time for watching TV show. *This gives patient more control over environment.*

10. Streamline treatments as much as possible. Have all equipment ready before starting; thoroughly instruct new personnel in routine and plan schedule for minimal interruptions. *Efficiency conveys respect for value of patient's time.*

Documentation

- Patient's expression of boredom, desire to carry out leisure activity, and frustration at being restricted
- Patient's interests, skills, and abilities to carry out activity
- Observations of patient's skill level and extent of participation in activity
- Patient's verbal expression of satisfaction with use of non-treatment-related time
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

Definition

State in which a patient with spinal cord injury at T6 or above experiences or risks life-threatening, uninhibited sympathetic response to a noxious stimulus

Assessment

- History of spinal cord trauma, including level of injury or lesion, previous episodes of dysreflexia
- Patient's description of symptoms, including headache, nasal congestion, blurred vision, chest pain, diaphoresis and flushing above level of lesion, chilling, paresthesias, cutis aserina ("goose flesh") above level of lesion, metallic taste, nausea
- Neurologic status, including level of consciousness, orientation, pupillary response, sensory status, motor status
- Cardiovascular status, including blood pressure, heart rate and rhythm, skin temperature and color

- Genitourinary status, including urine output, palpation of bladder, signs of urinary tract infection, examination of urinary assistive devices, such as catheter
- Gastrointestinal status, including nausea and vomiting, usual bowel pattern, bowel habits, last bowel movement, inspection of abdomen, auscultation of bowel sounds, palpation for masses, percussion for areas of dullness
- Environmental conditions, including changes in temperature, for example, cold draft; objects putting pressure on skin

Defining characteristics

- Major trauma (spinal cord injury at T6 or above), including paroxysmal hypertension (sudden periodic elevated blood pressure, systolic over 140 mm Hg and diastolic over 90 mm Hg); bradycardia or tachycardia (pulse under 60 or over 100 beats/minute); diaphoresis above injury, red splotches (vasodilation) on skin above injury, pallor below injury, diffuse

headache not confined to any nerve distribution area

- Minor trauma, including chilling (shivering with sensation of coldness or pallor of skin); conjunctival injection from excessive blood or tissue fluid in conjunctiva; Horner's syndrome from paralysis of cervical sympathetic nerve trunk (contracted pupils, partial ptosis, enophthalmos, sometimes loss of sweating on affected side of face); paresthesias; pilomotor reflex, blurred vision, chest pain, metallic taste, nasal congestion

Associated medical diagnoses (selected)

Spinal cord injury or tumor above T6 level

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Cause of dysreflexia identified and corrected. (1,3,4,5)
- Patient experiences cardiovascular stability as evidenced by _____ systolic range, _____ diastolic range, and _____ heart rate range. (1,2,3,4)
- Patient avoids bladder distention and urinary tract infection. (3a, 3d)
- Fecal impaction is absent. (3b)
- No noxious stimuli in environment. (3c)
- Patient states relief from symptoms of dysreflexia. (1,5)
- Patient encounters no or minimal complications. (1,2,3,4,5)
- Urinary elimination remains normal. (6,7)
- Fecal elimination remains normal. (6,7)
- Patient, family, or caregivers demonstrate knowledge and understanding of dysreflexia and articulate care measures. (6)
- Patient experiences few or no dysreflexic episodes. (6,7)

Interventions and rationales

1. Assess for signs of dysreflexia (especially in severe hypertension) *in order to detect the*

condition promptly.

2. Place patient in sitting position or elevate head of bed *to aid venous drainage from brain, lower intracranial pressure, and temporarily reduce blood pressure.*

3. Ascertain and correct probable cause of dysreflexia:

- a. Check for bladder distention and patency of catheter. If necessary, irrigate catheter with small amount of solution or insert a new catheter immediately. *A blocked urinary catheter can trigger dysreflexia.*
- b. Check for fecal mass in rectum. Apply dibucaine ointment (Nupercainal) to anus and 1 inch into rectum 10-15 minutes before removing impaction. *Failure to use ointment may aggravate autonomic response. ‡*
- c. Check environment for cold drafts and objects putting pressure on patient's skin, *which could act as dysreflexia stimuli.*
- d. Send urine for culture if no other cause becomes apparent *to detect possible urinary tract infection.*

4. If hypertension persists despite other measures, administer ganglionic blocking agent,

vasodilator, or other medication as ordered.

Drugs may be required if hypertension persists or if noxious stimuli cannot be removed. ‡

5. Take vital signs frequently *to monitor effectiveness of prescribed medications.*

6. Instruct patient, family, or caregiver about dysreflexia, its causes, symptoms, and care measures *to prepare them to handle possible dysreflexic emergencies.*

7. Implement and maintain bowel and bladder elimination programs *to avoid stimuli that could trigger dysreflexia.*

Documentation

- Objective assessment of dysreflexic episode
- Patient's description of dysreflexic episode
- Interventions to identify and eliminate causes of dysreflexia and patient's response to these
- Instructions given to patient, family, caregivers; patient's expressions of understanding and demonstrated ability to prevent or manage dysreflexic episode
- Implementation, alteration, or continuation of bladder and bowel programs
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Definition

Disruption in expected role functions within the family structure because of such situational crises as protracted physical or emotional illness

Assessment

- Assumed or expected roles
- Communication patterns within family for expressing affection, anger, confrontation, despair
- Family members
- Family's financial resources
- Family's past responses to crises
- Family's spiritual practices
- Family's understanding of patient's present condition
- Normal patterns of interaction among family members
- Number and ages of children
- Perceived impact of situation on family unit

or on assumed roles

- Significant others
- Support systems available to family

Defining characteristics

- Family members do not demonstrate respect for each other's views
- Family members unable to adapt to change
- Family system unable or unwilling to meet the emotional or physical needs of its members

Associated medical diagnoses (selected)

Any disease or illness that results in long-term disability or incapacitation, including: cancer, cerebrovascular accident, chronic renal failure, degenerative disease, dementia, terminal disease, traumatic injury

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Family members agree on who heads the family. (1)
- Family members develop adaptive responses by assuming duties carried out by the ill member; for example, meal preparation, transportation, shopping, laundry, cleaning, providing emotional support to other family members. (2,3,4,5)
- Family members identify support systems to assist them and participate in mobilizing those systems. (3,4,5,6)
- Family contacts a community agency or support group for continued assistance (depending on the type, severity, prognosis of illness); for example, American Cancer Society, American Lung Association, Arthritis Foundation, Hospice, Myasthenia Gravis Foundation, Multiple Sclerosis Society, National Kidney Foundation, Trauma Support Group. (7)
- Family members can share feelings about illness in the family with each other. (5,6)

Interventions and rationales

1. Identify the individual assuming the role as head of the family *to establish family hierarchy*

and functional ability.

2. Provide head of family with information necessary for decision making, such as updated information on patient's condition. *This avoids potential for misinterpretation and places responsibility for communication within family unit.*

3. Help head of the family decide which support systems need to be mobilized and used. *This allows opportunity to evaluate head of family's management ability and family's problem-solving ability.*

4. Provide emotional support to head of family regarding altered role and additional responsibilities. *This encourages family member to ventilate feelings, ask questions, seek help, and make decisions.*

5. Expedite communication within the family *to allow members to express their feelings about the present situation. This encourages supportive behavior to meet reciprocal needs in a crisis.*

6. Arrange for and participate in family conferences, if appropriate.

- a. Whenever possible, ensure privacy to family members for their discussions or

conferences.

- b. Include patient in family conferences and family interaction as often as possible. *These measures allow nurse to help family identify and work toward mutual goals and facilitate effective family coping.*

7. Make referrals to a psychiatric liaison nurse, social services, or community agencies, as appropriate *to provide family with access to additional coping resources.* ‡

Documentation

- Observations of family's reactions to situation
- Interventions to assist family and family's responses to those interventions
- Referrals to outside agencies
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Definition

Overwhelming sense of exhaustion and decreased capacity for physical and mental work, regardless of adequate sleep

Assessment

- History of underlying disease
- Respiratory status, including dyspnea on exertion, respiratory rate and depth
- Circulatory status, including skin color, temperature, turgor, blood pressure
- Age
- Sleep pattern, including hours slept at night, amount of time awake before becoming tired
- Nutritional status, including appetite, dietary intake, current weight, change from normal weight
- Neurologic status, including headaches
- Activity status, including type and duration of exercise, occupation, use of leisure time
- Psychosocial status, including personality stressors (finances, job, marital discord, etc.),

coping mechanisms, support systems (family, significant other), life-style

- Menstrual history, including length of periods, amount of menstrual flow

Defining characteristics

- Accident-prone
- Decreased libido
- Diminished performance
- Disinterest in surroundings
- Increased lability or irritability
- Introspection
- Lethargy or listlessness
- Perceived need for additional energy to accomplish routine tasks

Associated medical diagnoses (selected)

Anemia, cardiac failure, cerebrovascular accident, chronic fatigue syndrome, depression, Epstein-Barr virus, Guillain-Barré syndrome, multiple sclerosis, muscular atrophy, myasthenia gravis, poliomyelitis, rheumatoid arthritis

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient identifies measures to prevent or modify fatigue. (1,2,3,5,6)
- Patient explains relationship of fatigue to disease process and activity level. (4)
- Patient verbally expresses increased energy. (3,5,6,10)
- Patient incorporates as part of daily activities those measures necessary to modify fatigue. (3,5,6,7,8,9,10,11)
- Patient articulates plan to resolve fatigue problems. (11)
- Patient employs measures to prevent and modify fatigue. (1,2,3,5,6,7)

Interventions and rationales

1. Prevent unnecessary fatigue; for example, avoid scheduling two energy-draining procedures on the same day. *Using energy-conserving techniques avoids overexertion and potential for exhaustion.*
2. Conserve energy through rest, planning, and setting priorities *to prevent or alleviate fatigue.*
3. Alternate activities with periods of rest. Encourage activities that can be completed in

short periods of time or divided into several segments; for example, read one chapter of a book at a time. *Scheduling regular rest periods helps decrease fatigue and increase stamina.*

4. Discuss the effect of fatigue on daily living and personal goals. Explore with patient the relationship between fatigue and the disease process *to help increase patient compliance with the schedule for activity and rest.*
5. Reduce demands placed on patient; for example, ask one family member to call at specified times and relay messages to friends and other family members *to reduce physical and emotional stress.*
6. Structure patient's environment; for example, set up a daily schedule based on patient's needs and desires. *This encourages compliance with treatment regimen.*
7. Encourage patient to eat foods rich in iron and minerals, unless contraindicated. *This helps avoid anemia and demineralization.*
8. Postpone eating when patient is fatigued *to avoid aggravating the condition.*
9. Provide small, frequent feedings *to con-*

serve patient's energy and encourage increased dietary intake.

10. Establish a regular sleeping pattern. *Eight to 10 hours of sleep nightly helps reduce fatigue.*

11. Avoid highly emotional situations, *which aggravate patient's fatigue.* Encourage patient to explore feelings and emotions with a supportive counselor, clergy, or other professional *to help cope with illness.*

Documentation

- Patient's ability to describe the fatigue and its relationship to the disease process and condition
- Patient's ability to decrease fatigue by using various effective methods
- Patient's level of activity in relation to fatigue
- Patient's dietary intake
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

Definition

Feeling of physiologic or emotional disruption related to an identifiable source

Assessment

- History of experience with illness, hospitalization, surgery
- Availability of support systems, including family, significant other, friends, clergy
- Financial resources
- History of coping with fear
- Physiologic manifestations of fear, including pulse, respiratory rate, blood pressure, skin temperature, quality and pitch of voice
- Psychological manifestations of fear, including behavior, appetite, sleep pattern

Defining characteristics

- Diaphoresis
- Feeling of loss of control (actual or perceived)
- Geographic distance from family or friends caused by recent hospitalization
- Increased blood pressure
- Increased pulse and respiratory rate
- Increased questioning or verbalization
- Limited financial resources of family to travel
- Patient and spouse or significant other unaccustomed to separation
- Patient has no family or friends
- Voice tremors or pitch change

Associated medical diagnoses (selected)

This nursing diagnosis may occur in any hospitalized patient separated from family or friends. In elderly patients, hospitalization often disrupts routines or rituals.

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient identifies source(s) of fear. (1)
- Patient communicates feelings about separation from support systems. (1,2,3,4)
- Patient communicates feelings of comfort or satisfaction. (2,3,4,6,7)
- Patient uses situational supports to reduce fear. (4,5,6,9,10)
- Patient integrates into daily behavior at least one fear-reducing coping mechanism, such as asking questions about treatment progress, or making decisions about care. (4,5,6,8,9,10)

Interventions and rationales

1. Ask patient to identify source of fear; try to assess patient's understanding of situation. *Patient's perceptions may be erroneously based.*
2. If patient has no visitors, spend an extra 15 minutes each shift in casual conversation; encourage other staff members to stop for brief visits *to help patient cope with separation.*
3. Help patient maintain contact with family on a daily basis:
 - a. Arrange for telephone calls.
 - b. Help write letters.
- c. Promptly convey messages to patient from family and vice-versa.
- d. Encourage patient to have pictures of loved ones.
- e. Provide privacy for visits; take patient to day room or other quiet area. *These measures help patient re-establish and maintain social relationships.*
4. Involve patient in planning care and setting goals *to renew confidence and give sense of control in a crisis situation.*
5. Instruct patient in relaxation techniques, such as imagery and progressive muscle relaxation, *to reduce symptoms of sympathetic stimulation.*
6. Administer antianxiety medications as ordered and monitor effectiveness. *Drug therapy may be needed to manage high anxiety levels or panic disorders. ‡*
7. Answer questions and help patient understand care *to reduce anxiety and correct misconceptions.*
8. When feasible and where policies permit, relax visiting restrictions *to reduce patient's sense of isolation.*
9. Allow a close family member or friend to

participate in care *to provide an additional source of support.*

10. Support family and friends in their efforts to understand patient's fear and to respond accordingly *to help them understand that patient's emotions are appropriate in context of situation.*

Documentation

- Patient's expressions of concern about illness, hospitalization, separation from support system, overt expressions of fear
- Observations of physiologic and behavioral manifestations of patient's fear
- Interventions performed to allay patient's fears and encourage healthful coping mechanisms
- Patient's response to interventions
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Definition

Feelings of threat or danger to self arising from an identifiable source

Assessment

- History of experience with illness, hospitalization, surgery, etc.
- Availability of support systems, including family, significant other, friends, clergy
- Financial resources
- History of coping with fear
- Neurologic status, including mental status, orientation, sensory status
- Physiologic manifestations of fear, including pulse, blood pressure, respiratory rate, skin temperature
- Psychological manifestations of fear, including behavior, appetite, sleep pattern
- Quality and pitch of voice

Defining characteristics

- Diaphoresis
- Expresses feelings of aloneness imposed by others
- Expresses feelings of being different from others
- Increased blood pressure
- Increased pulse and respiratory rate
- Increased questioning or verbalization
- Preoccupation with own thoughts
- Projects hostility in voice and behavior
- Sad, dull affect
- Seeks to be alone or wants someone at the bedside constantly
- Speaks no English and understands no English
- Speaks no English but understands English
- States that there has been no similar situation in the past
- Uncommunicative, withdrawn, no eye contact
- Verbally expresses fear of the unknown
- Voice tremors or pitch changes

Associated medical diagnoses (selected)

Acute renal failure with hemodialysis or peritoneal dialysis, acute respiratory failure with mechanical ventilation, bowel resection with colostomy or ileostomy, brain tumor, coronary artery bypass surgery, craniocerebral trauma, sensory loss (blindness, deafness), spinal cord injury, tracheostomy or laryngectomy

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient identifies source(s) of fear. (1)
- Patient states understanding of procedures. (2,3)
- Patient verbally expresses comfort with surroundings. (4,5,6)
- Patient manifests no physical signs or symptoms of fear. (1,2,3,4,5,6)
- Patient uses available support systems to assist in coping with fear. (7,8,9,10)
- Patient integrates into daily behavior at least one fear-reducing coping mechanism, such as asking questions about treatment progress, making decisions about care, etc. (5,6)

Interventions and rationales

1. Encourage patient to identify source(s) of fear. *Patient's perceptions may be erroneously based.*
2. Explain all treatments and procedures, answering any questions patient might have. Present information at patient's level of understanding or acceptance *to reduce patient's anxiety and enhance cooperation.*
3. Orient patient to surroundings. Make any adaptations to compensate for sensory defi-

cits. *This enhances patient's ability to orient to time, place, person, and events.*

4. Assign the same nurse to care for patient whenever possible *to provide consistency of care, enhance trust, and reduce threat often associated with multiple caregivers.*
5. Spend time with patient each shift *to allow time for expression of feelings, provide emotional outlet, and allow feeling of acceptance.*
6. Involve patient in planning and providing care *to give patient some control over the situation and restore sense of self-esteem.*
7. Orient family to patient's specific needs, allowing family members to participate in giving care. *This helps them provide effective support.*
8. Request that family bring pictures and other small, personal objects to patient. *This helps alleviate patient's altered mental state by familiarizing the environment.*
9. Arrange for family member or friend to stay with patient *to help patient cope with fears.*
10. If a language barrier is the source of fear, use family and other resources in the hospital (such as an interpreter) *to help reduce patient's fear and aid effective communication.*

Documentation

- Patient's verbal expressions of fear
- Behavioral and physiologic manifestations of fear
- Interventions performed to reduce patient's fear
- Patient's response to interventions
- Family's involvement in patient care
- Patient's response to family involvement
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

Definition

Excessive loss of body fluid and electrolytes

Assessment

- History of fluid loss, such as vomiting, nasogastric tube drainage, diarrhea, hemorrhage
- Vital signs
- Fluid and electrolyte status, including weight, intake and output, urine specific gravity, skin turgor, mucous membranes
- Laboratory studies, including serum electrolytes, blood urea nitrogen, hemoglobin, hematocrit, stool cultures

Defining characteristics

- Altered electrolytes
- Clinical evidence of body fluid or blood loss
- Dry mucous membranes
- Dry or cold, clammy skin
- Fever
- Low blood pressure
- Oliguria
- Output greater than intake
- Poor skin turgor
- Rapid, shallow respirations
- Rapid, thready pulse
- Thirst
- Weakness
- Weight loss

Associated medical diagnoses (selected)

Bowel fistula, burns, dialysis, duodenal ulcer (perforated), esophageal varices (ruptured), food poisoning, fractures (femur), hemothorax, hyperosmolar nonketotic syndrome (HNKS), large amounts of diuretics, metabolic acidosis, multisystem trauma, nasogastric tubes, thoracic surgery

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Vital signs remain stable. (1,2)
- Skin color and temperature are normal. (1,2)
- Electrolyte levels stay within normal range. (3,4)
- Fluid volume remains adequate. (1,3,4,5,6,9,10)
- Patient produces adequate urine volume. (4,5)
- Patient has normal skin turgor and moist mucous membranes. (6)
- Urine specific gravity remains between 1.005 and 1.010. (7)
- Fluid and blood volume return to normal. (1,2,3,4,5,6,7,8,9,10)
- Patient expresses understanding of factors that caused fluid volume deficit. (11)

Interventions and rationales

1. Monitor and record vital signs every 2 hours or as often as necessary until stable. Then monitor and record vital signs every 4 hours. *Tachycardia, dyspnea, or hypotension may indicate fluid volume deficit or electrolyte imbalance.*
2. Cover patient lightly. Avoid overheating to

prevent vasodilatation, blood pooling in extremities, and reduced circulating blood volume.

3. Measure intake and output every 1 to 4 hours. Record and report significant changes. Include urine, stool, vomitus, wound drainage, nasogastric drainage, chest tube drainage, and any other output. *Low urine output and high specific gravity indicate hypovolemia.*
4. Administer fluids, blood or blood products, or plasma expanders, *to replace fluids and whole blood loss and facilitate fluid movement into intravascular space.* Monitor and record effectiveness and any adverse effects. ‡
5. Weigh patient at the same time daily *to give more accurate and consistent data. Weight is a good indicator of fluid status.*
6. Assess skin turgor and oral mucous membranes every 8 hours *to check for dehydration.* Give meticulous mouth care every 4 hours *to avoid dehydrating mucous membranes.*
7. Test urine specific gravity every 8 hours. *Elevated specific gravity may indicate dehydration.*
8. Do not allow patient to sit or stand as long

as circulation is compromised to avoid orthostatic hypotension and possible syncope.

9. Measure abdominal girth every shift *to monitor for ascites and third-space shift.* Report changes.

10. Administer and monitor medications *to prevent further fluid loss.* ‡

11. Explain reasons for fluid loss and teach patient how to monitor fluid volume — for example, by recording daily weight and measuring intake and output. *This encourages patient involvement in personal care.*

Documentation

- Patient's complaints of thirst, weakness, dizziness, palpitations
- Observations of physical findings
- Intake and output (amount and type)
- Patient's weight
- Interventions performed to control fluid loss
- Patient's response to interventions
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Fluid volume deficit, high risk for
related to excessive loss through
artificial routes (such as indwelling tubes)

48

Definition

Presence of risk factors that can lead to excessive fluid and electrolyte loss

Assessment

- History of problems that can cause fluid loss, such as vomiting, diarrhea, indwelling tubes, hemorrhage
- Vital signs
- Fluid and electrolyte status, including weight, intake and output, urine specific gravity, skin turgor, mucous membranes, electrolytes

Risk factors

- Altered intake
- Clinical evidence of fluid or blood loss through artificial orifices or lumens, wounds, and drainage tubes
- Increased fluid output
- Thirst
- Urinary frequency

Associated medical diagnoses (selected)

Bowel fistula, breast cancer with mastectomy, burns, esophageal fistula, esophageal varices (ruptured), intestinal obstruction, paralytic ileus

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Vital signs remain stable. (1)
- Skin color and temperature remain normal. (1)
- Patient maintains urine output of at least _____ ml hourly. (2)
- Electrolyte values remain within normal range. (3)
- Patient maintains intake at _____ ml/24 hours. (5,6,8,9,10,11)
- Intake equals or exceeds output. (4,5,6,7,8,10)
- Patient returns to normal, appropriate diet. (11)

Interventions and rationales

1. Monitor and record vital signs every 4 hours. *Fever, tachycardia, dyspnea, or hypotension may indicate hypovolemia.*
2. Measure urine output every hour. Record and report an output of less than _____ ml/hour. *Decreased urine output may indicate reduced fluid volume.*
3. Monitor serum electrolyte levels and report abnormalities. *Indwelling tube drainage may cause significant electrolyte imbalance.*

4. Measure and record drainage from all tubes and catheters, *taking it into account when replacing lost fluid.*
5. Obtain and record patient's weight at the same time every day *to give accurate data. Weight is good indicator of fluid status.*
6. When copious drainage appears on dressings, weigh dressings every 8 hours and record with other output sources. *Excessive wound drainage causes significant fluid imbalances (1 kg dressing equals about 1 liter of fluid).*
7. Cover wounds *to minimize fluid loss and prevent skin excoriation.* ‡
8. Monitor skin turgor each shift *to check for dehydration;* report any decrease.
9. Maintain parenteral fluids or blood transfusions at prescribed rate *to prevent further fluid loss or overload.* ‡
10. Force oral fluids when possible and indicated *to enhance replacement of lost fluids.* (Bowel sounds should be present with patient awake before giving oral fluids.) ‡
11. Progress patient to the appropriate diet, as ordered, *to help achieve fluid and electrolyte balance.* ‡

Documentation

- Observations of physical findings
- Intake and output
- Drainage from indwelling tubes and catheters, including amount, color, consistency
- Amount, color, and odor of drainage on dressings
- Patient teaching about fluid intake and diet
- Patient's response to interventions
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Fluid volume deficit, high risk for related to excessive loss through physiologic routes

49

Definition

Presence of risk factors that could lead to excessive fluid and electrolyte loss

Assessment

- History of problems that can cause fluid loss, such as vomiting, diarrhea, hemorrhage
- Vital signs
- Fluid and electrolyte status, including weight, intake and output, urine specific gravity, skin turgor, mucous membranes, serum electrolytes, blood urea nitrogen

Risk factors

- Any disorder that places patient at risk for fluid volume deficit
- Hyperventilation
- Increased fluid output
- Intake alteration
- Thirst
- Urinary frequency

Associated medical diagnoses (selected)

Altered level of consciousness, diabetes insipidus, diabetes mellitus, diarrhea-producing disorders (such as salmonellosis), organic brain syndrome

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- No signs of dehydration appear. (1,2,3,4,5,11,12)
- Patient's fluid intake exceeds output. Intake _____ ml/24 hours; output _____ ml/24 hours. (6,7,8,9)
- Patient expresses understanding of need to maintain adequate fluid intake. (10)
- Patient demonstrates skill in weighing self accurately and recording weight. (10)
- Patient measures and records own intake and output. (10)

Interventions and rationales

1. Monitor skin turgor each shift and report any decrease. *Poor skin turgor is a sign of dehydration.*
2. Examine oral mucous membranes each shift. *Dry mucous membranes are a sign of dehydration.*
3. Test urine specific gravity each shift. Monitor laboratory values and report abnormal findings to doctor. *Increased urine specific gravity may indicate dehydration. Elevated hematocrit and hemoglobin also indicate dehydration.*

4. Monitor vital signs every 4 hours. *Tachycardia, hypotension, dyspnea, or fever may indicate fluid volume deficit.*
5. Weigh patient daily and record. *Daily weights help estimate body fluid status.*
6. Administer and monitor parenteral fluids, as ordered, *to replace fluid losses.* ‡
7. Determine patient's fluid preferences *to enhance intake.*
8. Keep oral fluids at bedside within patient's reach and encourage patient to drink. *This gives patient some control over fluid intake and supplements parenteral fluid intake.*
9. Maintain accurate record of intake and output *to aid estimation of patient's fluid balance.*
10. Instruct patient in maintaining appropriate fluid intake, including recording daily weight, measuring intake and output, recognizing signs of dehydration. *This encourages patient and caregiver participation in care, and enhances patient's sense of control.*
11. Monitor electrolyte values and report abnormalities. *Fluid loss may cause significant electrolyte imbalance.*
12. Administer and monitor medication, such

as antiemetics and antidiarrheals, to prevent fluid losses. ‡

Documentation

- Observations of patient's fluid volume status
- Intake and output
- Patient's willingness or ability to drink enough to maintain fluid volume
- Patient's response to nursing interventions
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Definition

Excess fluid resulting from compromised regulatory mechanisms (internal physiologic controls that help the body adapt to changing needs, such as renin-angiotensin, antidiuretic hormone, aldosterone, hydrogen-bicarbonate ion exchange)

Assessment

- Neurologic status, including level of consciousness, orientation, mental status
- Cardiovascular status, including skin color, temperature, turgor, jugular venous pressure, central venous pressure and pulmonary artery pressure (if available), heart rate and rhythm, blood pressure, heart sounds, ECG, hemoglobin, and hematocrit
- Respiratory status, including rate, depth, pattern of respiration, breath sounds, chest X-ray, arterial blood gases
- Renal status, including intake and output, urine specific gravity, weight, serum electro-

lytes, serum and urine osmolality, blood urea nitrogen, creatinine, serum protein

- Endocrine status, including general appearance, size and body proportions, skin color and condition, distribution of body hair

Defining characteristics

- Change in mental status, including mood and personality changes, restlessness and confusion, acute stress and anxiety
- Change in cardiovascular status, including edema, jugular venous distention, central venous pressure changes and pulmonary artery changes, positive hepatojugular reflux, increased heart rate, blood pressure changes, third heart sound, ECG changes, decreased hemoglobin and hematocrit
- Change in respiratory status, including increased respiratory rate, changes in respiration pattern, dyspnea, orthopnea, crackles, pulmonary congestion on X-ray
- Changes in renal status, including intake

greater than output; oliguria, high urine specific gravity, weight gain, anasarca, altered electrolytes, change in osmolality, increased blood urea nitrogen, increased creatinine, decreased serum protein

- Changes in endocrine status, including mental status changes, abnormal fat distribution, increased blood pressure

Associated medical diagnoses (selected)

Acute glomerulonephritis, acute renal failure, chronic renal failure, congestive heart failure, Cushing's syndrome, hypothyroidism or myxedema, Laënnec's cirrhosis, malnutrition, primary aldosteronism, pyelonephritis, syndrome of inappropriate antidiuretic hormone, systemic lupus erythematosus

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Blood pressure remains within the range of not lower than _____ and not higher than _____. (1,5)
- Patient demonstrates no signs of hyperkalemia on ECG. (1,2,5)
- Patient maintains intake of no more than _____; output no less than _____. (2)
- Urine specific gravity remains between _____ and _____. (2,5)
- Hematocrit stays above _____. (3)
- Blood urea nitrogen, creatinine, sodium, and potassium stay within acceptable levels for specific patient. (3)
- Patient plans 24-hour fluid intake, as prescribed. (4,6,7)
- Patient tolerates restricted intake with no physical or emotional discomfort. (2,5,8,9,10,11)
- Patient's skin remains intact and infection-free. (12,13)
- Patient assists with activities of daily living without undue fatigue. (14,15)
- Patient ambulates and carries out activities of daily living safely and comfortably. (16,17)
- Patient demonstrates skill in selecting per-

mitted foods, such as those low in sodium, low in potassium, etc. (20)

- Patient describes signs and symptoms that require medical treatment. (21)

Interventions and rationales

1. Monitor blood pressure, pulse, cardiac rhythm, temperature, and breath sounds at least every 4 hours; record and report changes. *Changed parameters may indicate altered fluid or electrolyte status.*
2. Carefully monitor intake, output, and urine specific gravity at least every 4 hours. *Intake greater than output and elevated specific gravity may indicate fluid retention or overload.*
3. Monitor blood urea nitrogen (BUN), creatinine, electrolytes, hemoglobin, and hematocrit. *BUN and creatinine indicate renal function; electrolytes, hemoglobin and hematocrit help indicate fluid status.*
4. Weigh daily before breakfast, as ordered, to provide consistent readings. Check for signs of fluid retention, such as dependent edema, sacral edema, ascites.
5. Give fluids as ordered. Monitor I.V. flow rate

carefully *because excess I.V. fluids can worsen patient's condition.* ‡

6. If oral fluids are allowed, help patient make a schedule for fluid intake. *Patient involvement encourages compliance.* ‡
7. Explain the reasons for fluid and dietary restrictions to enhance patient's understanding and compliance.
8. Learn patient's food preferences and plan accordingly within prescribed dietary restrictions to enhance compliance. ‡
9. Provide mouth care every 4 hours. Keep mucous membranes moist with water-soluble lubricant to prevent them from dehydrating.
10. Provide sour hard candy to decrease thirst and improve taste.
11. Support patient with positive feedback about adherence to restrictions to encourage compliance.
12. Give skin care every 4 hours. Change patient's position at least every 2 hours. Elevate edematous extremities. *These measures enhance venous return, reduce edema, and prevent skin breakdown.*
13. Examine skin daily for signs of bruising or

(continued)

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Interventions and rationales (continued)

other discoloration. *Edema may cause decreased tissue perfusion with skin changes.*

14. Encourage patient to help in performing activities of daily living. *This boosts self-image and helps mobilize fluid from edematous areas.*

15. Alternate periods of rest and activity to avoid worsening fatigue caused by electrolyte imbalance.

16. Increase patient's activity level as tolerated; for example, ambulate, increase self-care measures performed by patient. *Gradually increasing activity helps body adjust to increased tissue oxygen demand and possible increased venous return.*

17. Apply antiembolism stockings or intermittent pneumatic compression stockings to increase venous return. Remove for 1 hour every 8 hours or according to hospital policy. ‡

18. Assess skin turgor to monitor for dehydration.

19. Measure abdominal girth every shift to monitor for ascites and report changes.

20. Have dietitian see patient to teach or reinforce dietary restrictions.

21. Educate patient regarding:

- environmental safety measures.
- fluid restriction and diet.
- signs and symptoms requiring immediate medical treatment.
- medications (name, dosage, frequency, therapeutic effects, and adverse effects).
- activity level.
- ways to prevent infection.

These measures encourage patient and significant others to participate more fully in care.

Documentation

- Expression of patient's needs, desires, or perceptions of the situation
- Specific changes in patient's physical status
- Observations about patient's response to treatment

- Observations about how patient appears to be coping with fluid and dietary restrictions
- Condition of skin and mucous membranes
- Interventions performed to alleviate or resolve diagnosis
- Evaluations for each expected outcome.

Care plan notes

‡ Indicates doctor-ordered instruction.

Care plan notes

Fluid volume excess

related to excess fluid intake or retention
or excess sodium intake or retention

51

Definition

Imbalance of water or sodium causing increased total body fluid or fluid volume shift from one compartment to another

Assessment

- Neurologic status, including level of consciousness, orientation, mental status
- Cardiovascular status, including skin color, temperature, turgor, jugular venous pressure, central venous pressure and pulmonary artery pressure (if available), heart rate and rhythm, blood pressure, heart sounds, ECG, hemoglobin, and hematocrit
- Respiratory status, including breath sounds, chest X-ray, arterial blood gases, and rate, depth, and pattern of respiration
- Renal status, including intake and output, urine specific gravity, weight, serum electrolytes, serum and urine osmolality, blood urea nitrogen, urine and serum creatinine, serum protein

Defining characteristics

- Altered electrolytes
- Anasarca
- Azotemia
- Central venous pressure changes
- Clinical evidence of increased fluids or salt intake or retention
- Edema
- Effusion
- Hepatojugular reflux
- Intake greater than output
- Mental status changes
- Oliguria
- Pulmonary congestion
- Restlessness and anxiety
- Shortness of breath, orthopnea
- Specific gravity changes
- Third heart sound
- Weight gain

Associated medical diagnoses (selected)

Cirrhosis, congestive heart failure, hypertension, hypoalbuminemia, portal vein thrombosis, psychogenic polydipsia, renal disease, small-bowel obstruction, severe burns

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient states ability to breathe comfortably. (1,2)
- Patient keeps fluid intake at _____ ml daily. (3,4,5)
- Patient returns to baseline weight. (6,7)
- Patient maintains vital signs within normal limits (specify). (4)
- Patient exhibits urine specific gravity of 1.005 to 1.010. (8)
- Patient has normal skin turgor. (11,12)
- Patient shows electrolytes within normal range (specify). (8,10)
- Patient avoids complications of excess fluid. (9,11,12,13)
- Patient states understanding of problem. (14)
- Patient demonstrates skill in health-related behaviors. (14)

Interventions and rationales

1. Help patient into a position that aids breathing, such as Fowler's or semi-Fowler's, *to improve ventilation.*
2. Administer oxygen, as ordered, *to enhance arterial blood oxygenation.* ‡
3. Restrict fluids to _____ ml per shift. *Ex-*

cessive fluids will worsen patient's condition. ‡

4. Monitor and record vital signs at least every 4 hours. *Changes may indicate fluid and electrolyte imbalances.*
5. Measure and record intake and output. *Intake greater than output may indicate fluid retention and possible overload.*
6. Weigh patient at same time each day *to obtain consistent readings.*
7. Administer diuretics *to promote fluid excretion.* Record effects. ‡
8. Test urine specific gravity every 8 hours and record results. Monitor laboratory values and report significant changes to doctor. *High specific gravity indicates fluid retention. Fluid overload may alter electrolyte levels.*
9. Assess patient daily for edema, including ascites and dependent or sacral edema. *Fluid overload or decreased osmotic pressure may result in edema, especially in dependent areas.*
10. Maintain patient on sodium-restricted diet, as ordered, *to reduce excess fluid and prevent reaccumulation.* ‡
11. Reposition patient every 2 hours, inspect skin with each turn, and institute measures as needed *to prevent skin breakdown.*

12. Apply antiembolism stockings or intermittent pneumatic compression stockings *to increase venous return.* Remove for 1 hour every 8 hours or according to institutional policy. ‡

13. Encourage patient to cough and deep-breathe every 2 to 4 hours *to prevent pulmonary complications.*

14. Educate patient regarding:

- a. maintenance of daily weight record.
 - b. daily measuring and recording of intake and output.
 - c. diuretic therapy.
 - d. dietary restrictions, especially sodium.
- These measures encourage patient and caregivers to participate more fully.*

Documentation

- Patient's perceptions of the situation
- Observations of physical findings
- Interventions to correct fluid volume excess
- Patient's responses to fluid and dietary restrictions
- Patient's demonstration of skills
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Definition

Interference in cellular respiration resulting from inadequate exchange or transport of oxygen and carbon dioxide

Assessment

- Neurologic status, including level of consciousness, orientation, mental status
- Respiratory status, including respiratory rate and depth, symmetry of chest expansion, accessory muscle use, cough, sputum, palpation for fremitus, percussion of lung fields, auscultation of breath sounds, arterial blood gases, pulmonary function studies
- Cardiovascular status, including skin color and temperature, heart rate and rhythm, blood pressure, hemoglobin and hematocrit, red blood cell count, white blood cell count, platelet count, prothrombin time, partial thromboplastin time, serum iron
- Activity status, including such functional ca-

pabilities as range of motion and muscle strength, activities of daily living, occupation

Defining characteristics

- Anxiety
- Bleeding tendency
- Confusion
- Cyanosis
- Decreased mental acuity
- Dizziness
- Dyspnea
- Fatigue
- Hypoxia
- Irritability
- Lethargy
- Red blood cell abnormalities
- Restlessness

Associated medical diagnoses (selected)

Carbon monoxide poisoning, chronic obstructive pulmonary disease, folic acid deficiency, hemophilia, hypoplastic anemia, iron-deficiency anemia, leukemia, pernicious anemia, polycythemia vera, sickle-cell anemia, thalassemia, thrombocytopenic purpura

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient carries out activities of daily living without weakness or fatigue. (1,2,3,4,5)
- No signs of active bleeding appear. (6,7,9,10)
- Hemoglobin and hematocrit return to normal level (specify). (7,8,9)
- Clotting profile remains within normal limits (specify). (8)
- Patient maintains adequate ventilation. (10,11)
- Patient communicates understanding of precautions needed to prevent bleeding. (12)

Interventions and rationales

1. Encourage patient to alternate periods of rest and activity. *Activity increases tissue oxygen demand; rest enhances tissue oxygen perfusion.*
2. If patient is on bed rest, help him into a comfortable position and raise the side rails *to prevent falls*. Have patient turn, cough, and deep-breathe every 4 hours *to prevent atelectasis or fluid buildup in lungs, and enhance blood oxygen level.*

3. Move patient slowly *to avoid orthostatic hypotension.*

4. Assist patient when out of bed *in case of dizziness*. Avoid bumps and scratches, *which may cause trauma and tissue bleeding.*

5. Plan patient's activities within level of tolerance, *to avoid fatigue.*

6. Provide gentle oral hygiene, *to avoid injuring oral mucosa.*

7. Check all urine and stools for blood *to detect internal bleeding*. Check for evidence of bleeding at least once every 8 hours. *Hemorrhage or bleeding may cause anemia.*

8. Administer blood or blood products and monitor for adverse reactions. ‡

9. Consolidate laboratory work *to avoid multiple needle-sticks and reduce chance of hematoma or hemorrhage in patients with altered clotting mechanisms*. Apply pressure for at least 1 minute after puncture *to promote clotting.*

10. Auscultate lungs every 4 hours and report abnormalities.

11. Monitor vital signs, cardiac rhythm, and arterial blood gas and hemoglobin levels. Report abnormalities.

12. Teach patient about safety at home and work, including:

- a. use of soft toothbrush
- b. use of an electric razor for shaving
- c. careful use of sharp objects, such as knives, tweezers, scissors
- d. monitoring of urine, stools, and sputum for blood and reporting results immediately if blood is present
- e. disadvantages and risks of smoking
- f. using medications (name, dosage, therapeutic effect, adverse effects, precautions). *These measures encourage patient and caregivers to participate in care.*

Documentation

- Patient's expression of personal feelings
- Observations about physical findings
- Results of laboratory studies that significantly affect nursing care
- Patient's response to interventions
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Definition

Interference in cellular respiration resulting from inadequate exchange or transport of oxygen and carbon dioxide

Assessment

- Neurologic status, including level of consciousness, orientation, mental status
- Respiratory status, including respiratory rate and depth, symmetry of chest expansion, use of accessory muscles, cough, sputum, palpation for fremitus, percussion of lung fields, auscultation of breath sounds, arterial blood gases, pulmonary function studies
- Cardiovascular status, including skin color and temperature, heart rate and rhythm, blood pressure, complete blood count
- Activity status, including such functional capabilities as range of motion and muscle strength, activities of daily living, occupation

Defining characteristics

- Anxiety
- Abnormal blood oxygen levels
- Confusion
- Cyanosis
- Dyspnea
- Hypercapnia
- Hypoxia
- Inability to move secretions
- Irritability
- Mental acuity decrease
- Restlessness
- Somnolence
- Tachycardia, arrhythmias

Associated medical diagnoses (selected)

Acute pulmonary edema, acute respiratory failure, adult respiratory distress syndrome, altitude sickness, carbon monoxide poisoning, cerebrovascular accident, gallbladder disorders requiring cholecystectomy, drug overdose (narcotics, barbiturates, tranquilizers), Guillain-Barré syndrome, head injury, myasthenia gravis, pneumonia, pulmonary embolism, spinal cord injury, conditions requiring thoracotomy

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient maintains respiratory rate within ± 5 of baseline. (1,2)
- Patient expresses feeling of comfort in maintaining air exchange. (3,4)
- Patient coughs effectively. (4,5)
- Patient expectorates sputum. (4,5,6)
- Patient sustains sufficient fluid intake to prevent dehydration: _____ ml/24 hours. (8,9)
- Patient performs activities of daily living to level of tolerance. (10,11)
- Patient has normal breath sounds. (1,2,3,4,5,6,7,8,9,10,11,12)
- Patient's blood gases return to baselines: _____ pH; _____ PaO₂; _____ PaCO₂; _____ SaO₂. (1,2,3,4,5,6,7,8,9,10,11,12)
- Patient performs relaxation techniques every 4 hours. (13,14)
- Patient uses correct bronchial hygiene. (5)

Interventions and rationales

1. Assess and record pulmonary status. Perform more frequently if patient's condition is unstable. *Poor pulmonary status may result in hypoxemia.*

2. Monitor vital signs and cardiac rhythm at least every 4 hours *to detect tachycardia and tachypnea that could warn of hypoxemia.*
3. Place patient in position that best facilitates chest expansion *to enhance gas exchange.*
4. Change patient's position at least every 2 hours *to mobilize secretions and allow aeration of all lung fields.*
5. Perform bronchial hygiene as ordered, including coughing, percussion, postural drainage, suctioning. *These measures promote drainage and keep airways clear.*
6. Give medications, as ordered, *to improve oxygenation.* Monitor and record efficacy and adverse reactions *to guide treatment.* ‡
7. Monitor oxygen therapy, *which increases alveolar oxygen concentration and enhances arterial blood oxygenation.* ‡
8. Record intake and output *to monitor patient's fluid status.*
9. Report signs of dehydration or fluid overload immediately. *Dehydration may hinder tissue perfusion and secretion mobilization; fluid overload may cause pulmonary edema.*
10. Assist patient with activities of daily living

to decrease tissue oxygen demand.

11. Include periods of rest in care plan *to reduce patient's tissue oxygen demand.*
12. Monitor arterial blood gas levels and notify doctor immediately if PaO₂ or SaO₂ drops or PaCO₂ rises. Administer endotracheal intubation and mechanical ventilation if needed. *This helps increase ventilation and gas exchange.* ‡
13. Teach patient relaxation techniques *to reduce tissue oxygen demand.*
14. Have patient perform relaxation techniques every 4 hours *to establish the routine and reduce oxygen demand.*

Documentation

- Patient's complaints of dyspnea, headache, restlessness
- Patient's expression of well-being
- Observations of physical findings
- Effectiveness of medications
- Other treatments performed by the nurse
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Definition

Grief response in anticipation of perceived personal loss

Assessment

- Type of loss expected
- Feelings about control of situation
- Usual patterns of coping with loss
- Ability of patient and family to grieve over loss
- Greatest fear about the loss
- Behavioral manifestations of grieving
- Somatic problems associated with grieving process, including appetite, sleep patterns, activity, libido
- Support systems, including family or significant other, friends, clergy

Defining characteristics

- Altered activity level
- Altered communication pattern
- Altered libido
- Anger
- Changes in eating habits
- Changes in sleep patterns
- Choked feelings
- Denial of potential loss
- Expression of distress at potential loss
- Guilt
- Potential loss of significant object
- Sorrow

Associated medical diagnoses (selected)

Diagnoses may include recently diagnosed chronic or terminal diseases, such as acquired immunodeficiency syndrome, amyotrophic lateral sclerosis, cancer, chronic obstructive pulmonary disease, diabetes mellitus, leukemia, lupus erythematosus, multiple sclerosis, and rheumatoid arthritis. Also conditions that require radical surgery, such as amputation of a limb, mastectomy, permanent tracheostomy or laryngectomy, radical neck surgery

Turn card over to find EXPECTED OUTCOMES,
INTERVENTIONS AND RATIONALES,
and DOCUMENTATION.

Expected outcomes †

- Patient identifies the perceived potential loss. (1)
- Patient expresses feelings about the potential loss. (2,3)
- Patient communicates understanding of grieving process and willingness to experience the process. (4)
- Patient exercises control by making decisions about care. (5)
- Patient uses healthful coping mechanisms to deal with potential loss. (6,7)
- Patient seeks support groups. (8)
- Patient makes plans for future. (9)

Interventions and rationales

1. Help patient identify the potential loss *because patient may be unable to pinpoint cause of anxiety.*
2. Plan time each shift to sit and listen to patient. If patient isn't ready to talk, spend the time in silence. *This demonstrates concern, understanding, and support for the patient.*
3. Encourage patient to express feelings about the potential loss and its impact on well-being and life-style. *This reinforces reality and helps*

alleviate guilt through self-assurance that effort was made to prevent loss.

4. Help patient understand grieving process and accept feelings being experienced as normal under the present circumstances. *This enhances patient's understanding and ability to cope.*
5. Encourage patient to make simple decisions related to care issues *to give patient a sense of functional ability and control.*
6. Emphasize patient's identified strengths. Provide positive reinforcement as patient demonstrates effective coping behavior. *This helps patient reestablish positive self-image and gain confidence.*
7. Encourage patient to use family, friends, or other support systems *to bolster coping ability.*
8. Inform patient about existing support groups in the facility and the community *to encourage patient to seek help from available resources.*
9. Help make a specific plan for coping after discharge *to enable patient to integrate the loss and adjust to life-style.*

Documentation

- Patient's verbal expressions
- Patient's eating, sleeping, activity patterns
- Observation of emotional responses, such as crying, anger, withdrawal
- Patient's attempt to gain control, such as making decisions, use of support systems
- Interventions performed to assist patient
- Patient's response to interventions
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

Definition

Prolongation of the normal grief response beyond the time one would expect resolution to have occurred

Assessment

- History of recent loss
- Patient's usual patterns of coping with loss, including cultural, intellectual, emotional
- Feelings related to loss
- Behavioral manifestations of grieving, including presence and intensity of specific behaviors
- Somatic problems associated with grieving process, including appetite, sleep patterns, activity level, libido
- Support systems, including family or significant other, friends, clergy

Defining characteristics

- Alterations in concentration or pursuit of tasks
- Alterations in eating habits, sleep patterns, dream patterns, activity level, libido
- Anger
- Crying
- Denial of loss
- Developmental regression
- Difficulty in expressing loss
- Expressions of guilt
- Expressions of unresolved issues
- Idealization of lost object
- Interference with life functioning
- Labile affect
- Loss of health, significant other, job, or anything of importance to patient
- Reliving of past experiences
- Sadness
- Verbal expression of distress at loss

Associated medical diagnoses (selected)

The presence and degree of dysfunctional grieving depends greatly on the inner personal strength and support systems of the patient. Examples of medical diagnoses in which dysfunctional grieving may occur include abruptio placenta or placenta previa resulting in fetal death; end-stage diseases of any kind; hysterectomy, mastectomy, orchiectomy, severe burns, spinal cord injury (partial or total paralysis), spontaneous or therapeutic abortion, surgical or traumatic limb amputation.

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient identifies the loss. (1,3)
- Patient expresses feelings about the loss. (1,2)
- Patient allows others to help in coping. (3)
- Patient begins using healthful coping mechanisms. (4)
- Patient communicates understanding that it's normal to grieve. (1,2,3,4)
- Patient seeks out healthful support systems. (5)
- Patient allows self to experience grieving process alone and with family. (6)
- Patient uses appropriate support systems. (7,9)
- Patient begins planning for future. (8,9)

Interventions and rationales

1. Encourage patient to use expressions of feeling that are most comfortable; for example, crying, talking, writing, drawing. *Dysfunctional grieving may result from inability to express feelings freely.*
2. Spend at least 15 minutes each shift with patient. Allow this time for expression of feelings. Place limits on behaviors that are de-

structive or exaggerated. *Inability to identify anger as normal response to loss may cause patient to behave aggressively toward self or others.*

3. Help patient focus realistically on changes the loss has brought about. *This is an initial step in planning for future, and helps patient find new patterns of rewarding interactions.*
4. Encourage patient's help in self-care activities, *to reduce intensity of patient's mourning and enhance sense of functional ability.*
5. Encourage patient to use available support systems, *to provide emotional strength.*
6. Encourage patient and family to reminisce. *Helping them engage in "life-review" often creates peaceful atmosphere in which loss acquires purpose and meaning.*
7. Inform patient and family about existing support groups in the agency and in the community, *to help prevent or reduce maladaptive emotional responses to loss.*
8. Help patient formulate goals for discharge and the future. *This helps patient to place loss in perspective and to move on to new situations and relationships.*
9. Refer patient to an appropriate mental

health professional. *Delayed grief reaction may indicate depression, which requires psychiatric intervention.*

Documentation

- Patient's verbal expressions of grieving
- Patient's observable behaviors, such as attempts at coping, interactions with family and staff
- Description of nursing interventions and patient's responses
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

Growth and development alteration

related to effects of physical disability

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Definition

State in which an individual deviates from norms for age

Assessment

- Age (chronological, developmental stage)
- Sex
- Nature of physical disability
- Past experience with hospitalization
- Family system (nuclear, extended, sibling position)
- Communication skills (verbal, nonverbal)
- Motor skills
- Socialization pattern
- Knowledge, including educational background, understanding of physical disability
- Mental status, including orientation, cognitive and perceptual ability, memory, affect, and mood behavior

Defining characteristics

- Delay or difficulty in performing skills typical of age group (motor, social, expressive)
- Inability to perform self-care or self-control activities appropriate for age
- Flat affect, listlessness, decreased verbal or nonverbal response

Associated medical diagnoses (selected)

This nursing diagnosis may apply to patients of all ages but will be limited here to include only those age 12 years or older. Diagnoses include cerebrovascular accident, conditions requiring amputation, head trauma, metastatic illness, orthopedic injuries, spinal cord injuries.

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient expresses concerns about physical disability. (1)
- Patient identifies changes in usual communication, motor, and socialization skills. (2)
- Patient states a desire to regain age-appropriate skills and behaviors to the extent possible. (3)
- Patient demonstrates age-appropriate skills and behaviors to the extent possible. (4)
- Patient, family, or significant other agrees to seek help from peer support groups or professional counselors to increase adaptive coping behaviors. (5)

Interventions and rationales

1. Spend specified amount of uninterrupted non-care-related time, perhaps 20 minutes twice daily, using active listening to encourage patient to express concerns. *Active listening, which includes attentive involvement and openness to patient's concerns without interpretation, allows patient to reveal concerns at own pace.*
2. Urge patient to identify normal skills and

behaviors and then describe how they should be altered in light of current disability. *Self-monitoring helps patient identify normal behaviors and relate behavioral changes to specific variables.*

3. Instruct patient on age-appropriate skills and behaviors (chronological and developmental) and request feedback on possible ways for patient to regain as many as possible. *This helps patient to recognize regressed behavior and noncompliance and to adjust accordingly.*
4. Give patient positive reinforcement for demonstrating appropriate skills and behaviors *to promote similar behavior in future.*
5. Tell patient, family, or significant other about social and professional support available and advise about the benefits of using services after discharge. *This encourages patient to seek help from available resources.*

Documentation

- Assessment of observed deviations from norm for patient's age group
- Patient's report of concern about disability
- Interventions performed to assist patient in

regaining age-appropriate skills and behaviors

- Patient's response to nursing interventions
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

Definition

Inability to maintain a healthy state

Assessment

- Neuromuscular status, including muscle strength and mass, gross and fine motor skills, joint mobility, electromyogram and electroencephalogram
- Abilities and limitations, including turning, transferring, ambulation, wheelchair use, driving, activities of daily living
- Knowledge of health practices, including body maintenance, preventive health needs, health team follow-up, safety measures
- Psychosocial support, including life-style, communication status (verbal, nonverbal, phone, written); family or significant other, finances

Defining characteristics

- Clinical evidence of deficiency in motor skills or ability
- Demonstrated lack of adaptive behaviors to internal or external environmental changes
- Demonstrated lack of knowledge regarding basic health practices
- Reported or observed inability to take responsibility for meeting basic health needs in any or all functional pattern areas

Associated medical diagnoses (selected)

Amyotrophic lateral sclerosis, brain tumor, cerebral palsy, cerebrovascular accident, head trauma, mental retardation, multiple sclerosis, muscular dystrophy, poliomyelitis, rheumatoid arthritis, spinal cord injury (quadriplegia, paraplegia), trauma

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient identifies necessary health maintenance activities. (1,3)
- Patient makes decisions about daily schedule. (2)
- Patient performs health maintenance activities according to level of ability (specify). (3,4)
- Patient communicates understanding of necessity for continuous self-monitoring of body functions. (3,4)
- Patient maintains muscle strength and joint mobility. (1,5,6)
- Patient demonstrates specific motor skills, such as brushing teeth. (6)
- Family or significant other demonstrates skill in carrying out activities patient cannot perform. (7)
- Patient identifies community and social resources available to help with health maintenance. (8)

Interventions and rationales

1. Discuss health maintenance needs with patient while carrying out routine activities *to reinforce their importance.*
2. Involve patient in decision making by allow-

ing choices in determining where, when, and how activities are to be carried out. Ask, for example, "Would you like a bath or shower in the morning or evening?" *Participation in decision making increases feelings of independence.*

3. Help patient perform health maintenance activities, such as daily skin inspection and weekly catheterization for residual urine. *Skill development should be encouraged to promote continuation after discharge.*

4. Instruct patient in specific skills needed in monitoring health status *to prompt participation in self-care.* Allow patient to carry out skills *to encourage independence.*

5. Perform or help patient perform passive and active range-of-motion exercises *to help maintain joint mobility and muscle strength.*

6. Identify level of mobility (independent in feeding, bathing; needs assistance to brush teeth; dependent in use of wheelchair) and communicate skill level to all personnel *to provide continuity and preserve level of independence.*

7. Educate family or significant other in skills that patient cannot perform unassisted, such

as bathing, maintaining hygiene, driving to appointments, transferring, or using walker. *This allows patient, family, or significant other to take active role in care.*

8. Consult with social service or other health team members to identify health resources (for example, Meals On Wheels or homemaker services), and help patient contact and arrange for follow-up. *These resources can help patient maintain independence after discharge.*

Documentation

- Patient's identified health needs and perceptions and limitations in achieving them
- Patient's willingness to make decisions and participate in health maintenance activities
- Observations of motor abilities, level of skill performance, and health status
- Patient's response to nursing interventions
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

Health maintenance alteration related to perceptual or cognitive impairment

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Definition

Inability to maintain a healthy state

Assessment

- Age
- Current health status
- History of neurologic, sensory, or psychological impairment
- Neurologic status, including level of consciousness, orientation, cognition (memory, insight, or judgment), sensory ability, motor ability
- Personal habits, such as smoking or alcohol consumption
- Psychosocial status, including support systems, personality, coping mechanisms, drug use, and communication status (verbal, non-verbal, phone, written)

Defining characteristics

- Impaired perceptual or cognitive functioning
- Impaired short-term or long-term memory
- Inability to concentrate or to follow instructions
- Lack of adaptive behaviors to internal or external environmental changes
- Lack of interest in health maintenance
- Reported or observed inability to take responsibility for meeting basic health needs in any or all functional pattern areas

Associated medical diagnoses (selected)

Alcoholic psychosis, Alzheimer's disease, anoxic encephalopathy, autism, bipolar disease (manic or depressive phase), brain tumor, cerebrovascular accident, drug dependence, head injury, Huntington's disease, Laënnec's cirrhosis, mental retardation, organic brain syndrome

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient maintains current health status. (1,2,4)
- Patient sustains no harm or injury. (1,2,3,4,6)
- Patient, family member, or significant other verbalizes feelings and concerns. (3,7,9,10)
- Patient, family member, or significant other explains health maintenance program. (3,4,5)
- Patient, family member, or significant other demonstrates health maintenance program. (5,6)
- Patient, family member, or significant other identifies health resources available. (9,10)
- Patient, family member, or significant other demonstrates appropriate coping skills. (8,10)

Interventions and rationales

1. Determine patient's capability to maintain health, degree of support available from family or significant other, degree of motivation, and level of dependence. Report any changes. *Comprehensive assessment provides a basis for evaluating future functional changes.*
2. Perform prescribed treatment for condition causing perceptual or cognitive impairment. Monitor progress and report favorable and ad-

verse responses. *Evaluating patient's responses to treatment and collaborating with doctor fosters appropriate care planning. ‡*

3. Help patient and family or significant other identify strengths and weaknesses in maintaining health; for example, self-care deficits present *to provide focus for interventions*. Also help family or significant other communicate with patient and understand what patient's behaviors mean. *This reduces patient's feelings of helplessness and gives sense of control over situation.*

4. Plan a health maintenance program with the patient and family or significant other, addressing current disabilities.

- a. Reorient patient as often as necessary, *to enhance reality testing and mental status*. Adapt environment to appear somewhat familiar to patient. Display such personal objects as pictures and clocks from patient's home.
- b. Provide a structured care program in writing *to give patient sense of security*.
- c. Have the same person provide care on an ongoing basis *to provide stability*.
- d. Fully describe all aspects of care *to elicit*

patient's cooperation.

- e. When discussing care, give short, simple explanations geared to patient's level of understanding. *This also enhances cooperation.*
 - f. If possible, prepare patient for any unexpected change *to minimize disruption*.
 - g. Provide ample time for patient to perform health maintenance tasks *to reduce frustration and encourage success*.
5. Urge family or significant other to carry out health maintenance practices. Demonstrate such necessary skills as bathing, feeding, and reality orientation; then have family member or significant other perform them under supervision. *Involving family or significant other allows them to solve problems with supervision and support.*
6. Instruct family member or significant other on how to maintain a safe environment *to reduce risk of patient injury*.
7. Encourage patient and family or significant other to verbalize feelings and concerns related to health maintenance *to help them develop greater understanding and better*

(continued)

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Interventions and rationales (continued)

manage their health.

8. Help family or significant other develop coping skills necessary to deal with patient. *If patient's illness is prolonged, family members or significant other could develop maladaptive coping strategies.*

9. Help family or significant other identify available social and community resources, such as a stroke support group or an Alzheimer's family support group. *This helps them gain social support and factual information, and allows them to express feelings associated with patient's disorder.*

10. Make referrals, as appropriate, to psychiatric liaison nurse, social services, etc., *to help prevent burnout among family members.*

Documentation

- Expressions of concern by patient and family or significant other about patient's inability to maintain health
- Observations of patient's impaired ability to perform self-care and response to treatment
- Patient's response to nursing interventions
- Instructions given to patient and family or significant other, their level of understanding, and demonstrated skill in carrying out the health maintenance program
- Referrals made for patient and family or significant other
- Evaluations for each expected outcome.

Care plan notes

Care plan notes

Health-seeking behaviors

related to absence of aerobic exercise
as a risk factor for coronary artery disease

59

Definition

State in which a patient in stable health actively seeks ways to alter personal health habits or the environment in order to move toward optimal health

Assessment

- Risk factor analysis, including age, diabetes, elevated cholesterol level, family history, lack of exercise, obesity, sex, smoking, stress
- Current health status
- Psychosocial status, including life-style and motivation
- Recognition and realization of potential growth, health, and autonomy

Defining characteristics

- Expressed concern about effect of environmental conditions on health status
- Expressed or observed desire for increased control of health practices
- Expressed or observed desire to seek higher level of wellness
- Expressed or observed lack of knowledge about health promotion behaviors
- Expressed or observed unfamiliarity with wellness community resources

Associated medical diagnoses (selected)

This diagnosis may coincide with any medical diagnosis, depending on the patient and the circumstances of hospitalization.

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient expresses understanding of benefits of an aerobic exercise program. (1)
- Patient states understanding of aerobic exercise guidelines. (2,3,4,5,8,9)
- Patient formulates specific exercise routine. (2,6)
- Patient states proper target heart rate to be achieved during exercise (60-80% of 220, minus patient's age). (2)
- Patient demonstrates ability to take pulse accurately. (7)

Interventions and rationales

1. Discuss benefits of regular exercise on the cardiovascular and respiratory systems and on mental health status *to introduce patient to the various benefits of an exercise program.*
2. Review basic components of an aerobic exercise routine, including:
 - a. Frequency (minimum of three times weekly)
 - b. Duration (minimum of 20 minutes, not including 5 to 10 minutes of warm-up and cool-down)
 - c. Intensity (work load should progress only

according to perceived exertion and target heart rate)

This informs patient of minimum requirements needed to get aerobic benefit from exercise program.

3. Discuss activities considered to be aerobic, such as walking, jogging, swimming, cycling, rowing. *Patient must build individualized program around enjoyable activity that meets aerobic criteria.*

4. Recommend that patient consult with doctor before starting exercise program *so patient can have exercise stress test, if necessary, and receive medical clearance for exercise program.*

5. Recommend either a supervised or unsupervised exercise program, depending on patient's motivation to continue the program. *Supervised program may help less motivated patients.*

6. Review warm-up and cool-down techniques, *which prevent abrupt changes in heart rate, and stretch working muscles to avoid injuries and an overworked heart.*

7. Instruct patient on independent pulse-taking techniques and monitor accuracy. *Patient must*

know how to take pulse to maintain correct heart rate range.

8. Instruct patient to notify doctor of any adverse symptoms experienced while exercising *to detect any adverse effects early.*

9. Provide patient with literature on exercise guidelines and community exercise programs *to reinforce teaching and provide references following discharge.*

Documentation

- Patient's expression of concern about promoting a higher level of wellness
- Patient's response to nursing interventions
- Instructions given and patient's understanding of the instructions
- Patient's plan of exercise after discharge from the hospital
- Patient's ability to take and record pulse
- Literature provided and referrals made to resources in the community
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

Health-seeking behaviors

related to elevated serum cholesterol level
as a risk factor for coronary artery disease

60

Definition

State in which a patient in stable health actively seeks ways to alter personal health habits or the environment in order to move toward optimal health

Assessment

- Risk factor analysis, including age, diabetes, elevated cholesterol level, family history, lack of exercise, obesity, sex, smoking, stress
- Current health status
- Psychosocial status, including life-style and motivation
- Recognition and realization of potential growth, health, and autonomy

Defining characteristics

- Expressed concern about effect of environmental conditions on health status
- Expressed or observed desire for increased control over health practices
- Expressed or observed desire to seek higher level of wellness
- Expressed or observed lack of knowledge about health promotion behaviors
- Expressed or observed unfamiliarity with wellness community resources

Associated medical diagnoses (selected)

This diagnosis may coincide with any medical diagnosis, depending on the patient and the circumstances of hospitalization.

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient states personal cholesterol level. (1)
- Patient reports that an elevated cholesterol level is a risk factor for coronary artery disease. (2)
- Patient states an appropriate dietary intake of fat and cholesterol to reduce cholesterol level. (3,4,5)
- Patient identifies ways to decrease cholesterol level. (6)
- Patient's cholesterol level declines to desired level. (1,2,3,4,5,6,7)
- Age-appropriate illness is prevented or signs and symptoms of disease, if present, are controlled. (1,2,3,4,5,6,7)

Interventions and rationales

1. Discuss patient's cholesterol level *to inform patient of desirable level.*
2. Discuss patient's understanding of cholesterol and its sources, *to increase understanding of the intrinsic and extrinsic sources, and the connection between high levels and coronary disease.*
3. Discuss ways to lower cholesterol level *to*

encourage compliance with post-discharge diet plan.

4. Provide literature on cholesterol *to reinforce teaching after discharge.*
5. Have patient meet with dietitian *to correct any dietary imbalances and reinforce healthy eating habits.*
6. Review outside resources available to patient *to provide follow-up and reinforcement after discharge.*
7. Review patient's dietary habits, foods high in cholesterol and saturated fats, and the importance of adhering to a low-cholesterol, low-fat diet *to reinforce dietary teaching and healthy eating habits.*

Documentation

- Patient's expression of concern about promoting a higher level of wellness
- Patient's response to nursing interventions
- Instructions provided and patient's understanding of instructions
- Literature recommended to or provided for the patient
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

Health-seeking behaviors
related to hypertension
as a risk factor for coronary artery disease

61

Definition

State in which a patient in stable health actively seeks ways to alter personal health habits or the environment in order to move toward optimal health

Assessment

- Risk factor analysis, including age, diabetes, elevated cholesterol level, family history, lack of exercise, obesity, sex, smoking, stress
- Current health status
- Psychosocial status, including life-style and motivation
- Recognition and realization of potential growth, health, autonomy

Defining characteristics

- Expressed concern about current environmental conditions on health status
- Expressed or observed desire for increased control over health practices
- Expressed or observed desire to seek higher level of wellness
- Expressed or observed lack of knowledge about health promotion behaviors
- Expressed or observed unfamiliarity with wellness community resources

Associated medical diagnoses (selected)

This diagnosis may coincide with any medical diagnosis, depending on the patient and the circumstances of hospitalization.

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient expresses an interest in learning new behaviors to help reduce blood pressure. (1,2)
- Patient states that hypertension is a risk factor for coronary artery disease. (1,2)
- Patient states an understanding of hypertension and how it relates to coronary artery disease. (3)
- Patient identifies and demonstrates appropriate interventions for lowering blood pressure. (4)
- Patient states own blood pressure range. (4)
- Patient expresses and demonstrates appropriate dietary measures used to reduce high blood pressure. (5)
- Patient maintains blood pressure within desired limits. (1,2,3,4,5)
- Age-appropriate illness is prevented or signs and symptoms of disease, if present, are controlled. (1,2,3,4,5)

Interventions and rationales

1. Discuss patient's understanding of hypertension and how it affects the body. Clarify any misconceptions. *This increases patient's awareness of hypertension's dangers.*

2. Inform patient of blood pressure reading each time it's taken *to reiterate range and give patient responsibility for maintaining it.*
3. Provide patient with pamphlets on hypertension *for reinforcement and easy reference after discharge.*
4. Instruct patient on methods to lower blood pressure *using simple exercise and dietary guidelines.*
5. Have patient meet with dietitian *to discuss low-sodium diet, assess eating habits, and make appropriate modifications.*

Documentation

- Patient's expression of concern about promoting a higher level of wellness
- Patient's response to nursing interventions
- Instructions provided and patient's understanding of instructions
- Literature recommended or provided to the patient
- Referrals made to community resources
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

Health-seeking behaviors
related to smoking
as a risk factor for coronary artery disease

62

Definition

State in which a patient in stable health actively seeks ways to alter personal health habits or the environment in order to move toward optimal health

Assessment

- Risk factor analysis, including age, diabetes, elevated cholesterol level, family history, lack of exercise, obesity, sex, smoking, stress
- Current health status
- Psychosocial status, including life-style and motivation
- Recognition and realization of potential growth, health, autonomy

Defining characteristics

- Expressed concern about current environmental conditions on health status
- Expressed or observed desire for increased control over health practices
- Expressed or observed desire to seek higher level of wellness
- Expressed or observed lack of knowledge about health promotion behaviors
- Expressed or observed unfamiliarity with wellness community resources

Associated medical diagnoses (selected)

This diagnosis may coincide with any medical diagnosis, depending on the patient and the circumstances of hospitalization.

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient states need to stop or decrease smoking. (1)
- Patient states the hazards of smoking and how it affects the body. (2,3,4)
- Patient understands ways to stop or decrease smoking. (5)
- Patient chooses which alternative to implement. (6)
- Patient stops smoking or enters a program to stop smoking. (1,2,3,4,5,6,7,8)
- Age-appropriate illness is prevented or signs and symptoms of disease, if present, are controlled (1,2,3,4,5,6,7,8)

Interventions and rationales

1. Determine patient's capability and motivation to promote a higher level of wellness. *Patient cannot be forced to change, but rather must have inherent desire.*
2. Discuss with patient the hazards of smoking to emphasize nicotine's long-term detriment to body and to support behavior change.
3. Assess patient's understanding of how smoking affects the body (blood pressure, cholesterol, clotting, heart rate). Clarify any

misconceptions. *This reinforces patient's desire to change behavior.*

4. Emphasize benefits of stopping smoking to reinforce behavior changes.
5. Review with patient past methods used to decrease or stop smoking (successful or not) to discover most effective methods for patient.
6. Suggest ways for patient to decrease or stop smoking, including the following:
 - a. List reasons to stop.
 - b. Set dates to stop.
 - c. Get support.
 - d. Switch brands.
 - e. Cut down on number smoked.
 - f. Perform alternative activities.

These measures provide patient with methods that can be individually implemented.

7. Provide literature on smoking cessation to reinforce teaching and provide easy reference after discharge.
8. Discuss resources available to support patient's attempts to stop smoking after discharge.

Documentation

- Patient's expression of concern about promoting a higher level of wellness
- Patient's response to nursing interventions
- Instructions provided and patient's understanding of instructions
- Referrals made to smoking cessation programs available in the hospital and community
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

Health-seeking behaviors
related to stress
as a risk factor for coronary artery disease

63

Definition

State in which a patient in stable health actively seeks ways to alter personal health habits or the environment in order to move toward optimal health

Assessment

- Risk factor analysis, including age, diabetes, elevated cholesterol level, family history, sex, lack of exercise, obesity, smoking, stress
- Current health status
- Psychosocial status, including life-style and motivation
- Recognition and realization of potential growth, health, autonomy

Defining characteristics

- Expressed concern about effect of current environmental conditions on health status
- Expressed or observed desire for increased control over health practices
- Expressed or observed desire to seek higher level of wellness
- Expressed or observed lack of knowledge about health promotion behaviors
- Expressed or observed unfamiliarity with wellness community resources

Associated medical diagnoses (selected)

This diagnosis may coincide with any medical diagnosis, depending on the patient and the circumstances of hospitalization.

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient states that stress is a risk factor for coronary artery disease. (1,4)
- Patient identifies and lists factors that create stress in life. (2)
- Patient voices understanding of how stress affects body. (3)
- Patient states ways to maximize positive aspects and minimize negative aspects of stress. (5,6)

Interventions and rationales

1. Inform patient that stress is a risk factor for many major health problems, including coronary artery disease. *Patient may be unaware that stress can contribute to disease and death.*

2. Review stressors in patient's personal and professional life and mechanisms used to cope with them. *This increases patient's awareness of stressors and provides baseline for stress management tools.*

3. Discuss how stress affects patient's body and how decreasing stress changes these effects. *This encourages patient to manage stress as a way to improve quality of life.*

4. Discuss the difference between type A and type B personalities. *Type A and B behaviors define personality type and provide framework for dealing with stress.*

5. Discuss with patient stress management techniques, including:
- a. perceiving situation differently
 - b. managing time
 - c. taking a mental health day or evening periodically
 - d. practicing relaxation techniques
 - e. being assertive when faced with unreasonable demands
 - f. improving self-image and self-esteem
 - g. exercising
 - h. facing problems and discussing alternatives with family or friends
 - i. setting realistic goals
 - j. relaxing standards of living. *These measures provide tools to manage stress.*

6. Review available community resources for stress management and provide literature to reinforce teaching after discharge.

Documentation

- Patient's expression of concern about promoting a higher level of wellness
- Patient's response to nursing interventions
- Instructions provided and patient's understanding of the instructions
- Referrals made and literature provided about stress management courses available in the community
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

Home maintenance management impairment

related to inadequate support system

64

Definition

Insufficient resources available to meet self-care needs adequately and safely in the patient's home

Assessment

- Psychosocial status
- Support systems, including family in the home, close friends, organizations with which the patient is affiliated; if patient lives alone, access to family, friends, pets
- Financial resources
- Home environment
- Patient's and family's or significant other's knowledge of disease and self-care requirements

Defining characteristics

- Household members describe outstanding debts or financial crisis
- Household members or patient express difficulty in maintaining a comfortable home
- Household members request assistance with home maintenance
- Lack of needed equipment or aids
- Overtaxed family members

Associated medical diagnoses (selected)

This diagnosis may coincide with any medical diagnosis and frequently occurs in geriatric or impoverished patients.

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient and family or significant other express need to make adjustments in home to help manage patient's condition. (1,2)
- Patient and family or significant other identify individuals or organizations that may provide assistance. (1,2,3,4)

Interventions and rationales

1. Help patient and family or significant other explore available resources *to help identify discharge problems and ease transition from hospital to home.*
2. Provide sufficient information to patient and family or significant other *to ensure knowledge necessary for them to make appropriate decisions.*
3. Refer patient to social service department, *which can assist with follow-up care after discharge.*
4. Suggest referral to home health agency, homemaker service, Meals On Wheels, or other appropriate outside agencies for assistance and follow-up. *The patient's various needs may be met best by a range of community services.*

Documentation

- Patient's and family's or significant other's perception of the problem
- Observations regarding the problem's magnitude
- Interventions performed to alleviate the problem
- Responses of others asked to assist with the problem
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

Definition

Subjective state in which an individual sees few or no available alternatives or personal choices and cannot mobilize energy on own behalf

Assessment

- Nature of current medical diagnosis
- Patient's and family's or significant other's knowledge of diagnosis and prognosis
- Actual or perceived self-care deficits (specify)
- Mental status, including cognitive functioning, affect, mood
- Communication, including verbal (speech content, quality, quantity) and nonverbal (body positioning, eye contact, facial expression)
- Available support systems, including clergy, family, friends
- Past experience with loss, including body

- part or function, death, residence, employment
- History of depression, bipolar disease, other psychiatric illness
- Coping mechanisms and decision-making ability
- Nutritional status, including alteration in appetite or body weight
- Sleep pattern
- Motivation level, including personal hygiene, therapies (physical and occupational therapy), and use of diversional activities
- Developmental stage (Erikson's model), including age and role in family

Defining characteristics

- Decreased affect
- Decreased verbalization
- Verbal cues, including frequent sighing and hopeless responses, such as "I can't," "What's the use," etc.

- Nonverbal cues, such as minimal eye contact, shrugging in response to questions, turning away from speaker
- Decreased appetite
- Increased sleep
- Decreased initiative and involvement in care

Associated medical diagnoses (selected)

Acquired immunodeficiency syndrome, amyotrophic lateral sclerosis, Alzheimer's disease, carcinomas, cerebrovascular accident, chronic congestive heart failure, chronic obstructive pulmonary disease, Crohn's disease, end-stage renal disease, multiple sclerosis, muscular dystrophy, psychiatric illness, rheumatoid arthritis, spinal cord injuries with paralysis

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient identifies feelings of hopelessness regarding current situation. (2)
- Patient demonstrates more effective communication skills, including direct verbal responses to questions and increased eye contact. (2,3)
- Patient resumes appropriate rest and activity pattern. (1,8)
- Patient participates in self-care activities and in decisions regarding care planning. (4,6,7)
- Patient uses diversional activities (specify). (5)
- Patient identifies social and community resources for continued assistance. (9,10)

Interventions and rationales

1. Follow medical regimen *to manage patient's physiologic condition and increase potential for patient's physiologic recovery.* ‡
2. Allow specific amount of uninterrupted, non-care-related time each shift to talk with patient. If patient chooses not to talk, spend time in silence. *This establishes rapport with depressed patient even if patient talks little.*
3. Encourage patient to talk about personal

assets and accomplishments and about improvements in condition, no matter how small. Give positive feedback. *Conversation will help in evaluating patient's self-concept and adaptive abilities; positive feedback reinforces patient's healthy perceptions.*

4. Direct patient's focus beyond current state. For example, "Your nasogastric tube will come out tomorrow and you'll feel more comfortable." *This helps instill hope in a depressed patient with no time perspective.*

5. Encourage patient to identify enjoyable diversions and to participate in them. *Lack of pleasurable activity can increase potential hazard of crisis situation.*

6. Keep patient informed of what to expect and when to expect it. *Accurate information reduces patient's anxiety.*

7. Involve patient and family or significant other in care planning, and allow patient to choose degree of self-involvement. Begin by offering patient a choice between two alternatives. Increase alternatives as initiative improves. *Cognitive disturbances associated with anxiety or depression often prevent patient from making healthy decisions.*

8. Use comfort measures (give back rub, dim room light, reduce noise level, minimize procedures) in addition to prescribed sleep medication, *to help induce sleep.*

9. Refer patient and family or significant other to other disciplines (dietitian, social worker, clergy, mental health clinical nurse specialist) or support groups (I Can Cope, Ostomy Support Group, Reach For Recovery) as necessary. *These groups give patient chance to discuss illness with others similarly afflicted.* ‡

10. Help patient mobilize resources before discharge, including contacting family and follow-up appointments to referral groups. *This helps give patient a sense of future direction.*

Documentation

- Patient's and family's knowledge of current condition
- Patient's mental status
- Patient's verbal and nonverbal behaviors
- Interventions to increase patient's feelings of hope, self-worth, and initiative in self-care
- Patient's and family's responses to nursing interventions
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Definition

Subjective state in which an individual sees few or no available alternatives or personal choices and cannot mobilize energy on own behalf

Assessment

- Nature of illness or injury
- Activity or rest pattern before illness or injury
- Past experience with prolonged inactivity
- Actual or perceived self-care deficit (specify)
- Mental status, including affect, cognitive functioning, mood
- Communication, including verbal (speech content, quality, quantity) and nonverbal (body positioning, eye contact, facial expression)

Defining characteristics

- Absence of diversion
- Decreased affect
- Decreased appetite
- Despondent mood
- Frequent crying
- Increased sleep
- Lack of attention to personal grooming
- Poor eye contact
- Verbal cues with hopeless content

Associated medical diagnoses (selected)

Cardiovascular disease, orthopedic injuries requiring skeletal traction, pulmonary disease requiring ventilatory support, vertebral fracture requiring prolonged bed rest, spinal cord injuries

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient identifies feelings of hopelessness regarding current situation. (2)
- Patient demonstrates more effective communication. (3)
- Patient initiates self-involvement in care. (1,3,4)
- Patient describes persons, events, and interventions that instill hope. (2,5,6)
- Patient joins in diversional activities. (5)
- Patient resumes appropriate sleep pattern and dietary intake. (1,3)
- Patient mobilizes support systems as necessary. (5)
- Patient begins to make plans regarding activity after discharge. (5,7)

Interventions and rationales

1. Follow medical regimen *to manage patient's physiologic condition and increase potential for patient's physiological recovery.* ‡
2. Visit frequently, allowing for specific amount of uninterrupted, non-care-related time each shift to talk with patient. Encourage verbal response with open-ended statements and questions. *This establishes rapport with a de-*

pressed patient even if patient talks little.

3. Provide structured schedule of daily routine, including morning care, meals, therapies, and rest periods; post schedule within patient's range of vision. *A structured environment helps patient move beyond emotional self-absorption and focus on external factors.*
4. Encourage patient's participation in self-care to the extent possible *to reduce patient's feeling of helplessness.*
5. Ask patient to identify support systems and enjoyable diversions and encourage their use. *Absence of supportive persons or pleasurable diversions increases potential hazard of a crisis situation.*
6. Ask family member or significant other to bring patient a few personal belongings from home, such as a radio, family photographs, clock, or pillow. *A familiar environment will reduce patient's stress.*
7. Assist patient with plans for resuming activity after discharge. *As feelings of hopelessness subside, patient will be more willing to discuss future plans.*

Documentation

- Patient's perception of current situation
- Patient's previous rest or activity pattern
- Patient's mental status
- Patient's verbal and nonverbal behavior
- Interventions to increase patient's hope, initiative, and involvement in self-care and diversional activities
- Patient's response to nursing interventions
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Definition

Elevation of body temperature above normal range

Assessment

- History of pathologic conditions known to cause dehydration, such as anorexia nervosa or infection
- Medications (diuretics, for example)
- Physiologic manifestations of fever, including vital signs
- Skin temperature
- Skin color
- Fluid and electrolyte status, including blood urea nitrogen, creatinine, intake and output, mucous membranes, serum electrolytes, skin turgor, urine specific gravity
- Neurologic status, including level of consciousness, mental status, orientation
- Nutritional status, including current weight, dietary pattern, normal weight

- Psychosocial status, including change in financial status, coping skills, recent traumatic event

Defining characteristics

- Flushed skin
- Fever
- Increased respiratory rate
- Seizures
- Skin warm to touch
- Tachycardia

Associated medical diagnoses (selected)

Anorexia nervosa, depression, diabetes mellitus (uncontrolled), drug toxicity, GI dysfunction (involving vomiting, diarrhea, anorexia), heat exhaustion, infection, postoperative status.

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Temperature remains normal. (1,2,3,4)
- Fluid balance remains stable (intake equal to or greater than output). (4,6,7,8,9)
- Patient states increased comfort. (3,5)
- Complications, such as seizures, are avoided. (1,2,3,4,5,6)
- Patient identifies risk factors that exacerbate the problem. (10,11)
- Patient states measures to prevent dehydration. (10,11)

Interventions and rationales

1. Take patient's temperature every 4 hours, or more often if indicated, *to evaluate effectiveness of interventions*. Identify and record route *to ensure accurate data comparison*.
2. Administer antipyretic medication as ordered *to reduce fever*. Record effectiveness. ‡
3. Employ measures to reduce excessive fever, such as removing blankets and placing loin cloth over patient, applying ice bags to axilla and groin, sponging with tepid water, and using hypothermia blanket for temperature greater than _____. *These measures promote patient comfort and lower body*

temperature. ‡

4. Monitor and record heart rate and rhythm, central venous pressure, blood pressure, respiratory rate, level of responsiveness, and skin temperature at least every 4 hours. *Increased heart rate, decreased central venous pressure, and decreased blood pressure may indicate hypovolemia, which leads to decreased tissue perfusion. Cool and blanched or mottled skin may also indicate decreased tissue perfusion. Increased respiratory rate compensates for tissue hypoxia.*
5. Observe patient for confusion or disorientation. Report changes in mentation to doctor. *Changed levels of consciousness may result from tissue hypoxia.*
6. Determine patient's preference for liquids (specify). *Using them facilitates adequate hydration.*
7. Keep liquids at bedside and within reach *to allow patient easy access.*
8. Encourage patient to drink as much fluid as possible unless contraindicated. *Vigorous fluid intake can cause fluid overload or cardiac decompensation that may worsen patient's condition.*

9. Treat patient for dehydration:

- a. Monitor and record intake and output accurately.

- b. Administer I.V. fluids as ordered.

These measures avoid excessive loss of water, sodium chloride, and potassium. ‡

10. Discuss precipitating factors with patient, if known, *to develop recommendations for keeping cool and avoiding heat-related illnesses.*

11. Encourage adherence to other aspects of health care management, including dietary habits *to help reduce fever*. Patient should drink plenty of fluids *to replace losses from sweating*. Water, fruit juices, vegetable juices, or iced tea are recommended.

Documentation

- Physical findings
- Nursing interventions carried out
- Effectiveness of medications
- Patient's response to nursing actions (behavioral, cognitive, physiologic)
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Definition

State in which body temperature is reduced below normal range

Assessment

- History of present illness
- Circumstances surrounding development of hypothermia
- Age
- Medication history
- Neurologic status, including level of consciousness, mental status, motor status, sensory status
- Cardiovascular status, including blood pressure, capillary refill, ECG, heart rate and rhythm, pulses (apical, peripheral), temperature
- Respiratory status, including arterial blood gases, breath sounds, and rate, depth, and character of respirations
- Integumentary status, including color, temperature, and turgor

- Nutritional status, including current weight and dietary pattern
- Fluid and electrolyte status, including blood urea nitrogen, intake and output, serum electrolytes, and urine specific gravity
- Psychosocial status, including behavior, financial resources, mood, and occupation

Defining characteristics

Major characteristics include cool skin, mild shivering, and moderate pallor. Minor characteristics include cyanotic nail beds, hypertension, slow capillary refill, piloerection, and tachycardia.

Associated medical diagnoses (selected)

Addison's disease, alcohol intoxication, cerebrovascular accident, cirrhosis, drug overdose, frostbite, hypoglycemia, myocardial infarction, myxedema, pancreatitis, pituitary insufficiency, perioperative reaction (especially after general anesthesia), Wernicke's encephalopathy

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Body temperature is normal. (1,2,3,4,5)
- Skin feels warm and dry. (1,2,3)
- Heart rate and blood pressure remain within normal range. (3)
- Patient does not shiver. (4,5)
- Patient expresses feelings of comfort. (4,5)
- Patient shows no complications associated with hypothermia, such as soft tissue injury, fracture, dehydration, hypovolemic shock if warmed too quickly. (1,2,3,4,5)
- Patient understands how to prevent recurrent episodes of hypothermia. (6,7)

Interventions and rationales

1. Monitor body temperature at least every 4 hours or more frequently, if indicated, *to evaluate effectiveness of interventions*. Record temperature and route *to allow accurate data comparison*. *Baseline temperatures vary, depending on route used. If temperature is $\leq 95^{\circ}\text{F}$, low-reading thermometer should be used.*
2. Monitor and record neurologic status at least every 4 hours. *Falling body temperature and metabolic rate reduce pulse rate and*

blood pressure, which reduces blood perfusion to brain, resulting in disorientation, confusion, and unconsciousness.

3. Monitor and record heart rate and rhythm, blood pressure, and respiratory rate at least every 4 hours. *Blood pressure and pulse decrease in hypothermia. During rewarming, patient may develop hypovolemic shock. During warming, ventricular fibrillation and cardiac arrest may occur, possibly signaled by irregular pulse.*

4. Provide supportive measures, such as placing patient in warm bed and covering with warm blankets; removing all wet or constrictive clothing; covering all metal or plastic surfaces that contact patient's body. *These measures protect patient from heat loss.*

5. Follow the prescribed treatment regimen for hypothermia:

- a. Administer medications to prevent shivering. Monitor effectiveness and record. ‡
- b. Administer analgesic for pain associated with warming. Monitor effectiveness and record. ‡
- c. Use hypothermia blanket if temperature drops below _____. Warm patient to

_____. ‡

- d. If administering large volumes of I.V. fluids, consider using a fluid warmer.

During rewarming, watch for shivering to prevent overheating. External rewarming with blankets is appropriate in mild hypothermia. I.V. fluids may be needed during rewarming to prevent hypovolemic shock.

6. Discuss precipitating factors with patient, if indicated. *Factors may include living conditions, finances, and medications (such as sedatives and alcohol).*

7. Instruct patient in precautionary measures to avoid hypothermia, such as dressing warmly even when indoors, eating proper diet, remaining as active as possible. *Precautions avoid accidental hypothermia.*

Documentation

- Patient's complaints of coldness, shivering
- Observations of physical findings
- Interventions carried out to resolve the nursing diagnosis
- Patient's response to interventions, including physiologic, behavioral, and cognitive
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Definition

Involuntary passage of stool

Assessment

- History of neuromuscular disorder
- Bowel elimination status, including usual bowel pattern, history of bowel disorder (laxative or enema use), incontinence characteristics (frequency, awareness of need to defecate, precipitating factors), presence or absence of anal sphincter reflex, bowel sounds
- Fluid and electrolyte status, including intake and output, urine specific gravity, skin turgor, mucous membranes
- Nutritional status, including usual dietary pattern, appetite, tolerance or intolerance for foods, current weight, change from normal weight
- Activity status, including type of exercise, frequency, duration

Defining characteristics

- Clinical evidence of neuromuscular deficits
- Involuntary passage of stool

Associated medical diagnoses (selected)

Amyotrophic lateral sclerosis, brain or spinal cord tumor, cerebrovascular accident, diabetic neuropathy, Guillain-Barré syndrome, hemorrhoidectomy, Huntington's disease, multiple sclerosis, myasthenia gravis, spinal cord injury

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient establishes and maintains a regular pattern of bowel care. (A1,2,4) or (B1,2)
- Patient states understanding of bowel care routine. (A2,3,4,5)
- Patient or caregiver demonstrates skill in carrying out bowel care routine with help from nurse. (A2,3,4,5,6)
- Patient or caregiver demonstrates increasing skill in performing bowel care routine independently. (A1,2,3,4,5,6,7,8,9 and B1,2)
- Patient participates in social activities. (A9)

Interventions and rationales

A. Upper motor neuron lesion (anal reflex intact)

1. Establish regular pattern for bowel care; for example, after breakfast every other day, maintain patient in upright position after inserting suppository and allow ½ hour for suppository to melt and maximum reflex response to occur. *Regular pattern encourages adaptation and routine physiologic function.* ‡
2. Discuss bowel care routine with patient and family to promote feelings of safety, adequacy and comfort.

3. Demonstrate bowel care to patient and caregivers to reduce anxiety from lack of knowledge or involvement in care.
4. Observe return demonstration of bowel care routine by patient and caregivers to check skills and establish a therapeutic relationship.
5. Establish a date when patient or caregivers will carry out bowel routine independently, with supportive assistance, to reassure patient of dependable care.
6. Instruct patient and family on need to regulate foods and fluids that cause diarrhea or constipation to encourage good nutritional habits.
7. Maintain dietary intake diary to identify irritating foods; instruct patient to avoid foods that are spicy, rich, or produce gas, to prevent painful flatulence.
8. Obtain order allowing modified bowel preparations for tests and procedures to avoid interrupting routine and to encourage regular bowel function. ‡
9. Encourage patient to use protective padding under clothing, changing it as necessary to prevent odor, skin breakdown, or embarrassment, and to promote positive self-image.

B. Lower motor neuron lesion (flaccid sphincter)

1. Establish regular pattern for bowel care; for example, after breakfast every other day, turn patient on left side, put waterproof pads under buttocks, administer prescribed enema and allow to remain in place 2 to 5 minutes. Then perform digital removal of stool, clean perianal area, and remove soiled pads. *These procedures encourage regular physiologic function, stimulate peristalsis, minimize infection, and promote comfort and elimination.*
2. Follow interventions for upper motor neuron lesion.

Documentation

- Patient's feelings about the problem and the bowel routine
- Bowel care routine and administration of suppositories and enemas
- Description of incontinent episodes, including known precipitating factors, time of day, etc.
- Patient's and caregivers' skills in bowel care
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Definition

Involuntary passage of stool

Assessment

- History of neurologic or psychiatric disorder
- Fluid and electrolyte status, including intake and output; skin turgor, urine specific gravity, and mucous membranes
- Gastrointestinal status, including usual bowel habits, change in bowel habits, stool characteristics (color, amount, size, consistency), pain or discomfort, inspection of abdomen, auscultation of bowel sounds, palpation for masses and tenderness, percussion for tympany and dullness, laxative and enema use
- Characteristics of incontinence, including frequency, time of day, before or after meals, relationship to activity, behavior pattern (restlessness, etc.)

- Neurologic status, including orientation, level of consciousness, memory, cognitive ability

Defining characteristics

- Involuntary passage of stool
- Lack of awareness of need to defecate
- Lack of awareness of passage of stool

Associated medical diagnoses (selected)

Alzheimer's disease, brain tumor, cerebrovascular accident, coma, head injury, meningitis, organic brain syndrome

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient experiences bowel movement every _____ day(s) when placed on commode/toilet at _____ a.m./p.m. (1,2)
- Patient's skin remains clean and intact. (9)
- Patient gains or improves control of incontinent episodes. (2)
- Caregiver states understanding of bowel routine. (3)
- Caregiver demonstrates skill in placing patient on commode. (4,5)
- Caregiver demonstrates skill in use of suppository, if indicated. (1,6)
- Caregiver understands and explains relationship of food and fluid regulation to promotion of continence. (7,8)
- Patient maintains self-respect and dignity through participation and acceptance within group. (10)

Interventions and rationales

1. Establish a regular pattern for bowel care; for example, after breakfast every other day, place patient on commode chair 1 hour after inserting suppository; allow patient to remain upright for 30 minutes for maximum response;

then cleanse anal area. *Procedure encourages adaptation and routine physiologic function.*

2. Monitor and record incontinent episodes; keep baseline record for 3 to 7 days *to track effectiveness of toileting routine.*

3. Discuss bowel care routine with family or caregiver *to foster compliance.*

4. Demonstrate bowel care routine to family or caregiver *to reduce anxiety from lack of knowledge or involvement in care.*

5. Arrange for return demonstration of bowel care routine *to help establish therapeutic relationship with patient and family or caregiver.*

6. Establish a date when family or caregiver will carry out bowel care routine with supportive assistance; *this will assure patient of dependable care.*

7. Instruct family or caregiver on need to regulate foods and fluids that cause diarrhea or constipation *to encourage helpful nutritional habits.*

8. Maintain a diet log *to identify irritant foods*, and then eliminate them from patient's diet.

9. Cleanse and dry perianal area after each incontinent episode *to prevent infection and*

promote comfort.

10. Maintain patient's dignity by using protective padding under clothing, by removing patient from group activity after incontinent episode, and by cleansing and returning patient to group without undue attention. *These measures prevent odor, skin breakdown, and embarrassment, and promote patient's positive self-image.*

Documentation

- Patient's level of awareness, response to incontinent episodes, and acceptance of bowel care routine
- Family's or caregiver's response to incontinence and to establishment and implementation of a bowel care routine
- Observation of effects of bowel care routine, episodes of incontinence, stool characteristics, and condition of skin
- Family's or caregiver's skill in carrying out bowel routine and modifying diet
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

Definition

Involuntary and unpredictable passage of urine in socially unacceptable situations, where patient usually does not recognize warning signs of bladder fullness

Assessment

- History of mental illness
- Age
- Sex
- Vital signs
- Genitourinary status, including frequency, voiding pattern
- Fluid and electrolyte status, including blood urea nitrogen, creatinine, intake and output, mucous membranes, serum electrolytes, skin turgor
- Neuromuscular status, including daily living activities, mental status, mobility, sensory ability to perceive bladder fullness

- Psychosocial status, including behavior before and after voiding, support from family or significant other, impact of incontinence on self and others, stressors (family, job, change in environment)

Defining characteristics

- Incontinence
- Lack of awareness of need to control voiding
- Voiding that occurs in socially unacceptable situations

Associated medical diagnoses (selected)

Alzheimer's disease, cerebrovascular accident, dementia, emotional illness (anxiety, depression, schizophrenia, withdrawal, manipulative behavior), toxic confusional states (infection, myxedema, uremia, hepatic dysfunction, drug overdose)

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient voids in appropriate situations. (2,3,4)
- Patient does not void in unacceptable situations. (2,3,4)
- Complications are avoided or minimized. (1,2,3)
- Patient and family or significant other demonstrates skill in managing incontinence. (5)
- Patient discusses impact of incontinence on self and family or significant other. (6)
- Patient and family or significant other identifies resources to assist with care following discharge. (7)

Interventions and rationales

1. Monitor and record patient's voiding patterns *to ensure correct fluid replacement therapy.*
2. Assist with specific bladder elimination procedure, such as:
 - a. bladder training. Place patient on commode or toilet every 2 hours while awake and once during the night. *Successful bladder training revolves around adequate fluid intake, muscle-strengthening*

exercises, and carefully scheduled voiding times.

- b. rigid toilet regimen. Toilet patient at specific intervals (every 2 hours or after meals). Note whether patient was wet or dry and whether voiding occurred at each interval. *This helps patient adapt to routine physiologic function.*
- c. behavior modification. Reward continence or voiding in lavatory. Do not punish unwanted behavior, such as voiding in the wrong place. Reinforce behavior consistently, using social or material rewards. *This helps patient learn alternatives to maladaptive behaviors.*
- d. external catheter. Apply according to established procedure and maintain patency. Observe condition of perineal skin and cleanse with soap and water at least twice daily. *This ensures effective therapy and prevents infection and skin breakdown.*
- e. protective pads and garments. Use only when interventions have failed, *to prevent infection and skin breakdown and promote social acceptance.* Allow at least 4

to 6 weeks for trial period. *Establishing continence requires prolonged effort.*

3. Maintain continence based on patient's voiding patterns and limitations.
 - a. Use reminders.
 - b. Orient patient to toileting environment, time, activity, and place. *A structured environment offers security and helps patient with elimination problems.*
 - c. Stimulate patient's voiding reflexes (give patient drink of water while on toilet; stroke area over bladder; pour water over perineum). *External stimulation triggers bladder's spastic reflex.*
 - d. Provide hyperactive patient with distractor, such as magazine, to occupy attention while on toilet. *This reduces anxiety and eases voiding.*
 - e. Provide privacy and adequate time to void *to allow patient to void easily without anxiety.*
 - f. Praise successful performance *to give patient a sense of control and to encourage compliance.*
 - g. Change wet clothes *to accustom patient to dry clothes.*

(continued)

† Numbers following outcomes refer to interventions.

Care plan notes

Definition

Involuntary and unpredictable passage of urine in socially unacceptable situations, where patient usually does not recognize warning signs of bladder fullness

Assessment

- History of mental retardation, trauma, alcohol abuse
- Medication history
- Age
- Sex
- Vital signs
- Genitourinary status, including amount, extent of clothing wetness due to urine, frequency, palpation of bladder, urine leakage when standing or sitting, voiding pattern
- Fluid and electrolyte status, including blood urea nitrogen, creatinine, intake and output, mucous membranes, serum electrolytes, skin turgor, urine specific gravity

- Neuromuscular status, including manual dexterity, mental status, mobility, motor ability to start and stop urine stream, rectal exam (muscle tone, prostate size, fecal impaction), sensory ability to perceive bladder fullness
- Psychosocial status, including behavior before and after voiding, coping skills, support from family or significant other, perception of health problem, self-concept, stressors (finances, job, change in environment)

Defining characteristics

- Incontinence
- Nocturia
- Voiding that occurs before reaching an appropriate site or receptacle
- Warning signals of bladder fullness usually not recognized

Associated medical diagnoses (selected)

Alcohol abuse, Alzheimer's disease, closed head injuries, episodic loss of consciousness (seizures, hypoglycemia, dementia), mental retardation, toxic confusional states (infection, myxedema, uremia, hepatic dysfunction, drug overdose)

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient voids in appropriate situation using suitable receptacle. (2,3,4)
- Patient voids at specific times. (2,3)
- Patient has no wet episodes. (2,3,5)
- Patient maintains fluid balance; intake equals output. (1,4)
- Complications are avoided or minimized. (1,2,3,9)
- Patient and family or significant other demonstrate skill in managing incontinence. (6)
- Patient discusses impact of incontinence on self and significant other. (7)
- Patient and family or significant other identifies resources to assist with care following discharge. (8)

Interventions and rationales

1. Monitor patient's voiding pattern; document and report intake and output *to ensure correct fluid replacement therapy.*
2. Assist with specific bladder elimination procedure, such as:
 - a. bladder training. Place patient on commode or toilet every 2 hours while awake and once during the night. *Successful*

bladder training revolves around adequate fluid intake, muscle-strengthening exercises, and carefully scheduled voiding times.

- b. rigid toilet regimen. Toilet patient at specific intervals (every 2 hours or after meals). Note whether patient was wet or dry and whether voiding occurred at each interval. *This helps patient adapt to routine physiologic function.*
 - c. external catheter. Apply according to established procedure and maintain patency. Observe condition of perineal skin and cleanse with soap and water at least twice daily. *This ensures effective therapy and prevents infection and skin breakdown.*
 - d. protective pads and garments. Use only after incontinence management procedures have failed, *to prevent infection and skin breakdown and promote social acceptance.* Allow at least 4 to 6 weeks for trial period. *Establishing continence requires prolonged effort.*
3. Maintain continence based on patient's voiding patterns and limitations.

- a. Use reminders.
- b. Orient patient to toileting environment, time, and place of activity. *A structured environment offers security and helps patient with elimination problems.*
- c. Stimulate voiding reflexes. Give patient a drink of water while on the toilet; stroke the area over the bladder; pour water over the perineum. *External stimulation triggers bladder's spastic reflex.*
- d. For hyperactive patients, provide a distractor, such as a magazine, to occupy attention while on the toilet. *This reduces anxiety and eases voiding.*
- e. Provide privacy and adequate time to void *to allow patient to void easily without anxiety.*
- f. Praise successful performance *to give patient a sense of control and encourage compliance.*
- g. Change wet clothes *to accustom patient to dry clothes.*
- h. Teach family members and support personnel to assist, *thus reducing anxiety that results from noninvolvement and in-*

(continued)

† Numbers following outcomes refer to interventions.

Interventions and rationales (continued)

- creasing chances for successful treatment.*
- i. Respond quickly to patient's call light to avoid delays in voiding routine.
 - j. Choose patient's clothing to promote ease in dressing and undressing. (For example, use Velcro fasteners and gowns instead of pajamas.) *This reduces patient's frustration with voiding routine.*
4. Schedule patient's fluid intake to encourage voiding at convenient times. Maintain adequate hydration up to 3,000 ml daily, unless contraindicated. *Optimum time interval between voidings is based on reasonable distention of bladder. Limit fluid intake to 150 ml after supper to reduce need to void at night.*
5. Decrease patient's use of alcohol *to reduce sensory or mobility deficits.*
6. Instruct patient and family or significant other on continence techniques to be used at home. Have patient and family or significant other return demonstrations. *This will increase the chances for successful bladder retraining.*
7. Encourage patient and family or significant other to share feelings related to incontinence. *This allows specific problems to be identified and resolved. Attentive listening conveys recognition and respect.*
8. Refer patient and family or significant other to psychiatric liaison nurse, Visiting Nurses Association, support group, and similar resources when appropriate *to provide access to additional community resources.*
9. Keep skin as clean and dry as possible. Use mild soap and water *to cleanse urea burns and prevent skin breakdown.*

Documentation

- Observations of incontinence and response to treatment regimen
- Interventions to provide supportive care and patient's response
- Instructions given to patient and family or

significant other; return demonstration of knowledge and skills needed to carry out continence management techniques

- Patient's expression of concern about incontinence problem and motivation to participate in self-care
- Evaluations for each expected outcome.

Care plan notes

Care plan notes

Definition

Involuntary loss of urine, controlled by spinal cord reflex, occurring at somewhat predictable intervals when a specific bladder volume is reached

Assessment

- History of sensory or neuromuscular impairment
- History of urinary tract disease, trauma, surgery, or infection
- Genitourinary status, including bladder palpation, residual urine volume after voiding, urinalysis, urine characteristics, urine culture and sensitivity, voiding patterns
- Neuromuscular status, including anal sphincter tone, motor ability to start and stop urine stream, neuromuscular function, sensory ability to perceive bladder fullness and voiding, and involuntary voiding after stimulation of skin on abdomen, thighs, or genitals
- Fluid and electrolyte status, including blood

urea nitrogen, creatinine, intake and output, medication history, mucous membranes, serum electrolytes, skin turgor, urine specific gravity

- Sexuality status, including capability, concerns, and habits
- Psychosocial status, including coping skills, self-concept, and perception of problem by patient and family or significant other

Defining characteristics

- Frequency
- Interrupted, involuntary, or incomplete voiding
- Involuntary bladder contractions, which may occur with involuntary spasms of lower extremities
- No awareness of bladder filling
- No feelings of fullness or urge to void
- Normal or increased anal sphincter tone
- Reduced bladder capacity
- Voiding and involuntary contractions of the

extremities triggered by stimulation of skin on the abdomen, thighs, genitals

Associated medical diagnoses (selected)

Cerebrovascular accident, multiple sclerosis, Parkinson's disease, prolapsed intervertebral disk, upper motor neuron damage resulting from spinal cord tumor, spinal cord trauma, arteriosclerosis of spinal cord.

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient maintains fluid balance; intake equals output. (1,3,4)
- Complications are avoided or minimized. (1,2,3)
- Patient achieves urinary continence. (2)
- Patient and family or significant other demonstrate skill in managing urinary incontinence. (4)
- Patient discusses impact of incontinence on self, family, and significant others. (5)
- Patient and family or significant other identify resources to assist with care following discharge. (6)

Interventions and rationales

1. Monitor intake and output, *to ensure correct fluid replacement therapy*. Report output greater than intake.
2. Implement and monitor effectiveness of specific bladder elimination procedure, such as:
 - a. reflex arc stimulation. Patient who voids at somewhat predictable intervals may be able to regulate voiding by reflex arc stimulation. Voiding should be triggered

at regular intervals (for example, every 2 hours) by stimulating skin of abdomen, thighs, or genitals to initiate bladder contractions. Avoid stimulation at nonvoiding times. Stimulate primitive voiding reflexes by giving patient water to drink while he sits on the toilet, or pouring water over the perineum. *External stimulation triggers bladder's spastic reflex.*

- b. applying external catheter according to established procedure and maintaining patency. Observe condition of perineal skin and cleanse with soap and water at least twice daily. *Cleanliness avoids skin breakdown or infection. External catheter protects surrounding skin, promotes accurate output measurement, and keeps patient dry. Applying foam strip in spiral fashion increases adhesive surface and cuts risk of impaired circulation.*
- c. indwelling (Foley) catheter. Monitor patency and keep tubing free of kinks *to avoid drainage pooling and assure accurate therapy*. Keep drainage bag below level of bladder *to avoid urine reflux into bladder*. Perform catheter care according

to established procedure. Maintain closed drainage system *to prevent bacteriuria*. Secure catheter to leg (female) or abdomen (male) *to avoid tension on bladder and sphincter*.

- d. suprapubic catheter. Change dressing according to established procedure *to avoid skin breakdown*. Monitor patency and keep tubing free of kinks *to avoid drainage pooling in loops of catheter*. Keep drainage bag below bladder level *to avoid urine reflux into bladder*. Maintain closed drainage system *to prevent bacteriuria*.
 - e. changing wet clothes *to prevent patient from becoming accustomed to wet clothes*.
3. Encourage high fluid intake (2,500 ml daily, unless contraindicated) *to stimulate micturition reflex*. Limit fluid intake after 7 p.m. *to prevent nocturia*.
 4. Instruct patient and family or significant other on continence techniques to be used at home. Have patient and family member or significant other return demonstrations until

(continued)

† Numbers following outcomes refer to interventions.

Interventions and rationales (continued)

procedure can be performed well. *Patient education begins with assessment and depends on nurse's establishing therapeutic relationship with patient and family.*

5. Encourage patient and family or significant other to share feelings and concerns regarding incontinence. *A trusting environment allows nurse to make specific recommendations to resolve patient's problems.*

6. Refer patient and family or significant other to psychiatric liaison nurse, visiting nurse's association, support group, other resources as appropriate. *Community resources often provide health care not available from other health agencies.*

Documentation

- Observations of urologic condition and response to treatment regimen
- Interventions to provide supportive care and patient's response

- Instructions given to patient and family or significant other; return demonstration of knowledge and skills needed to carry out continence management techniques
- Patient's expression of concern about incontinence and its impact on body image and lifestyle; patient's motivation to participate in self-care
- Evaluations for each expected outcome.

Care plan notes

Care plan notes

Definition

Loss of urine (less than 50 ml) resulting from increased abdominal pressure

Assessment

- History of long-term use of tranquilizers, multiple pregnancies, prolonged or difficult labor, surgery, trauma, vaginal infections
- Age
- Sex
- Vital signs
- Genitourinary status, including inspection of abdomen for scars from previous surgeries, rectal examination, vaginal examination, voiding pattern, and leakage of urine during sneezing, laughing, vomiting, coughing, defecating, physical exertion, or change from prone to upright position
- Fluid and electrolyte status, including creatinine, blood urea nitrogen, estrogen levels, intake and output, mucous membranes, serum electrolytes, skin turgor

- Nutritional status, including appetite, dietary habits, present weight
- Neuromuscular status, including degree of neuromuscular function, motor ability to start or stop urine stream, sensory ability to perceive fullness
- Sexuality status, including capability, concerns, habits, and patterns
- Psychosocial status, including coping skills, self-concept, stressors (finances, family, job), and perception of problem by family members or significant others

Defining characteristics

- Dribbling with increased abdominal pressure
- Frequency
- Incontinence
- Urgency

Associated medical diagnoses (selected)

Atrophic senile vaginitis, atrophic urethritis secondary to estrogen deficiency, cystocele, gravid uterus, multiple pregnancies, obesity, pelvic fracture, pelvic tumor, disorders requiring radical prostatectomy or sphincterostomy; urethrocele, uterine prolapse

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient maintains continence. (1,2,5,9)
- Patient states increased comfort. (2,7)
- Patient states understanding of treatment. (2,3,4,9)
- Patient states understanding of surgical procedure. (7)
- Patient and family or significant other demonstrate skill in managing urinary elimination problems. (5,6,9)
- Patient and family or significant other identify resources to assist with care following discharge. (8,9,10)

Interventions and rationales

1. Observe patient's voiding patterns, time of voiding, amount voided, and whether voiding is provoked by stimuli. *Accurate, thorough assessment forms the basis of an effective treatment plan.*
2. Provide appropriate care for the urologic condition present, monitor progress, and report patient's responses to treatment. *Patient expects to receive adequate care and to participate in decisions regarding care. ‡*
3. Help patient to strengthen pelvic floor mus-

cles by Kegel exercises for sphincter control. *Exercises increase muscle tone and restore cortical control.*

4. Promote patient's awareness of condition through education *to help patient understand illness as well as treatment.*

5. Help patient reduce intra-abdominal pressure by:

- a. weight reduction
- b. avoiding heavy lifting
- c. avoiding chairs or beds that are too high or too low. *These measures reduce intraabdominal pressure and bladder pressure.*

6. Provide supportive measures:

- a. Respond to call light quickly, assign patient to bed next to bathroom, put night light in bathroom, and have patient wear clothing that's easily removed (gown rather than pajamas, Velcro fasteners rather than buttons or zippers). *Early recognition of problems promotes continence; easily removed clothing reduces patient frustration and helps achieve continence.*

b. Provide privacy during toileting *to reduce*

anxiety and promote elimination.

c. Have patient empty bladder before meals, at bedtime, and before leaving accessible bathroom area *to promote elimination, avoid accidents, and help relieve intraabdominal pressure.*

d. Limit fluids to 150 ml after dinner *to reduce patient's need to void at night.*

e. Encourage high fluid intake, unless contraindicated, *to moisten mucous membranes and maintain hydration.*

f. Before going on a long trip, patient may eat increased amount of salty food (unless contraindicated). *Increased sodium decreases urine production.*

g. Make protective pads available for patient's undergarments, if needed, *to absorb urine, protect skin, and control odors.*

7. If surgery is scheduled, give attentive, appropriate preoperative and postoperative instructions and care *to reduce patient's anxiety and build trust in caregivers.*

8. Encourage patient to ventilate feelings and concerns related to urologic problems. *This*

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

helps patient focus on specific problem.

9. Refer patient and family or significant other to psychiatric liaison nurse, support group, or other resources, as appropriate. *Community resources often provide health care not available from other health agencies.*

10. Alert patient and family or significant other to need for toilet schedule. Prepare for discharge according to individual needs *to ensure that patient will receive proper care.*

Documentation

- Observations of urologic condition and patient's response to treatment regimen
- Interventions to provide supportive care and patient's response to interventions
- Instructions given to patient and family or significant other on urologic problem present, their response to instructions, and demon-

strated ability to carry out self-care management

- Patient's expression of concern about the urologic problem and its impact on body image and life-style
- Patient's motivation to participate in self-care
- Evaluations for each expected outcome.

Care plan notes

Care plan notes

Definition

Continuous and unpredictable passage of urine

Assessment

- History of trauma, sensory or neuromuscular impairment, surgery, congenital anomalies
- Vital signs
- Age
- Sex
- Genitourinary status, including palpation of bladder, previous bladder elimination procedures, urinalysis, urine characteristics, use of urinary assistive devices, voiding pattern
- Fluid and electrolyte status, including BUN, creatinine, intake and output, mucous membranes, skin turgor, serum electrolytes
- Neuromuscular status, including degree of neuromuscular function, motor ability to start or stop urine stream, sensory ability to perceive bladder fullness
- Sexuality status, including capability, con-

cerns, and sexual partner

- Psychosocial status, including patient's perception of health problem, coping skills, family or significant other, self-concept

Defining characteristics

- Constant flow of urine occurs at unpredictable times without distention or uninhibited bladder contractions or spasms
- Incontinence refractory to treatments
- Lack of awareness of incontinence, perineal fullness, or bladder filling
- Nocturia

Associated medical diagnoses (selected)

Cerebral tumor; cerebrovascular accident; congenital anomalies, such as bladder exstrophy, ectopic ureters, and epispadias; diabetes mellitus; fistulas secondary to trauma, gynecologic procedures, long labor, or radiation therapy; multiple sclerosis; neuromuscular trauma related to abdominal perineal resections or retropubic prostatectomy; and spinal cord injury or tumor

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient maintains fluid balance; intake equals output. (1)
- Patient states increased comfort. (2,3,4)
- Complications are avoided or minimized. (2,3,4)
- Patient contains urine. (2,3)
- Patient and family or significant other demonstrate skill in managing incontinence. (4)
- Patient and family or significant other discuss impact of incontinence on their lives. (5)
- Patient and family or significant other identify resources to assist with care following discharge. (6)

Interventions and rationales

1. Monitor patient's voiding pattern; document and report intake and output *to ensure correct fluid replacement therapy.*
2. Assist with specific bladder elimination procedure ordered, such as:
 - a. external catheter. Apply according to established procedure and maintain patency. Avoid constriction. Observe condition of perineal area and cleanse with soap and water at least twice daily.

Reusable penile sheaths are available for long-term use. *Cleanliness prevents skin breakdown or infection. External catheter protects surrounding skin, promotes accurate output measurement, and keeps patient dry. Applying foam strip in spiral fashion increases adhesive surface and cuts risk of impaired circulation.*

- b. indwelling (Foley) catheter. Monitor patency and keep tubing free of kinks *to avoid drainage pooling and assure accurate therapy.* Keep drainage bag below level of bladder *to avoid urine reflux into bladder.* Cleanse urinary meatus according to established procedure *to reduce risk of infection.* Maintain closed drainage system *to prevent bacteriuria.* Secure catheter to leg (female) or abdomen (male) *to avoid tension on bladder and sphincter.* ‡
- c. suprapubic catheter. Monitor patency, change dressing, and cleanse catheter site according to established policy *to avoid skin breakdown.* Keep tubing free of kinks; keep drainage bag below level of bladder *to prevent urine reflux into*

bladder. Maintain closed drainage system *to prevent bacteriuria.* ‡

- d. body-worn appliances. These are body-worn "urinals" to fit over the penis, a drainage bag, and waist and leg straps for body attachment, *to protect skin and keep patient dry.* Selection depends on patient's self-help skills. Appliances need regular, careful washing *to protect skin and keep patient dry.*
 - e. incontinence aids. (1) Pad and pants: absorbent pad with protective waterproof shield. (2) Drip collector: absorbent pouch fits over penis. (3) Bed protector: absorbent pad protects bed. *These aids trap urine to keep it away from patient's skin.*
 - f. Disguise urinary bag by placing it in shopping bag or tote bag.
3. Provide supportive measures:
 - a. Regulate fluid intake on a specific schedule *to encourage voiding at convenient times.* Maintain adequate hydration up to 3,000 ml daily, unless contraindicated. Limit fluid intake to 150 ml after dinner *to*

(continued)

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Interventions and rationales (continued)

reduce need to void at night.

- b. Clothe patient to promote ease in dressing and undressing, and to accommodate appliance. (For example, use Velcro fasteners and gowns rather than pajamas.)

Unwieldy clothing increases patient frustration with voiding routine.

- c. Keep skin as clean and dry as possible to promote skin integrity. Treat urea burns by cleansing with mild soap and water.

4. Instruct patient and family or significant other on continence techniques for home use. Provide for return demonstrations. *Patient education begins with assessment and depends on nurse's establishing therapeutic relationship with patient and family.*

5. Encourage patient and family or significant other to share feelings and concerns related to incontinence. *A trusting environment allows nurse to make specific recommendations to resolve patient's problems.*

6. Refer patient and family or significant other to psychiatric liaison nurse, visiting nurse's association, support group, or other resources, as appropriate. *Community resources often provide health care not available from other health agencies.*

Documentation

- Observations of incontinence and response to treatment regimen
- Interventions to provide supportive care and patient's response to interventions
- Instructions given to patient and family or significant other, their understanding of information, and their demonstrated ability to carry out continence management techniques
- Patient's expressions of concern about incontinence and motivation to participate in self-care
- Evaluations for each expected outcome.

Care plan notes

Care plan notes

Definition

Involuntary passage of urine occurring shortly after a strong sense of urgency to void

Assessment

- History of cerebrovascular accident, urinary tract disease, spinal cord injury, surgery, infection
- Medication history
- Vital signs
- Genitourinary status, including cystometrogram, pain or discomfort, urinalysis, urine specific gravity, use of urinary assistive devices, voiding pattern
- Fluid and electrolyte status, including blood urea nitrogen, creatinine, intake and output, mucous membranes, postvoiding residual volume, skin turgor, serum electrolytes
- Neuromuscular status, including ambulation ability, degree of neuromuscular function, dexterity, and sensory ability to perceive fullness
- Sexuality status, including capability, con-

cerns, habits, and sexual partner

- Psychosocial status, including coping skills, self-concept, stressors (finances, family, job), and perception of health problem by patient, family, or significant other

Defining characteristics

- Bladder contraction or spasm
- Dysuria
- Frequency
- Hesitancy
- Incontinence
- Loss of urine regardless of position
- Nocturia
- Sensory or neuromuscular impairment of urinary tract
- Urgency

Associated medical diagnoses (selected)

Acute bladder infection, Alzheimer's disease, bladder cancer, brain trauma or tumor, cerebrovascular accident, dementia, incomplete supraspinal cord injury, interstitial cystitis, multiple sclerosis, outlet obstruction, Parkinson's disease, spinal compression, transverse myelitis, urethritis

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient maintains continence. (1,2,3,4,8)
- Patient states increased comfort. (2,5)
- Patient states understanding of treatment. (5,6)
- Complications are avoided or minimized. (1,2,3,7)
- Patient discusses impact of urologic disorder on self and family or significant other. (5,7,8)
- Patient and family or significant other demonstrate skill in managing incontinence. (2,4,7,8)

Interventions and rationales

1. Observe voiding pattern; document intake and output. *This ensures correct fluid replacement therapy and provides information about patient's ability to void adequately.*
2. Provide appropriate care for urologic condition present, monitor progress, and report patient's responses to treatment. *Patient should receive adequate and qualified care, and be allowed to understand and participate in care as much as possible. ‡*
3. Provide supportive measures:
 - a. Administer medication and monitor effec-

- tiveness. *Patient's knowledge that pain can be alleviated reduces tension and anxiety. ‡*
- b. Prepare pleasant toilet environment that's warm, clean, and free of odors *to promote continence.*
 - c. Place commode to the right of bed, or assign a bed next to the bathroom. *A bedside commode or convenient bathroom requires less energy expenditure than bedpan.*
 - d. Keep bed and commode at same level *to facilitate patient's movements.*
 - e. Provide good lighting from bed to bathroom *to reduce sensory misinterpretation.*
 - f. Remove all obstacles between bed and bathroom *to reduce chance of falling.*
 - g. Provide clock *to help patient maintain voiding schedule through self-monitoring.*
 - h. Unless contraindicated, maintain fluids to 3,000 ml daily *to moisten mucous membranes and ensure hydration; limit patient to 150 ml after supper to reduce need to void at night.*
 - i. Have patient wear clothes that are easily

removed (gown instead of pajamas, Velcro fasteners instead of buttons or zippers) *to reduce frustration and delay in voiding routine.*

- j. If caught short on way to bathroom, instruct patient to stop and take a deep breath. *Anxiety and rushing caused by anxiety may strengthen bladder contractions.*
4. Assist with specific bladder elimination procedures:
 - a. bladder training. Place patient on commode every 2 hours while awake and once during the night. Provide privacy. Gradually increase intervals between toileting. *These measures aim to restore a regular voiding pattern.*
 - b. rigid toilet regimen. Toilet patient at specific times (for example, every 2 hours). *This aids adaptation to routine physiological function. Keep baseline micturition record for 3 to 7 days to monitor toileting effectiveness.*
 5. Encourage patient to ventilate feelings and concerns related to his or her urologic prob-

(continued)

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Interventions and rationales (continued)

lem to *identify patient's fears.*

6. Explain urologic condition to patient and family or significant other; include instructions on preventive measures and established bladder schedule. *Patient education begins with educational assessment and depends on establishing a therapeutic relationship with patient and family.* Prepare patient for discharge according to individual needs, *so patient can practice under supervision.*

7. Instruct patient and family or significant other on continence techniques for home use. *This reduces fear and anxiety resulting from lack of knowledge of patient's condition, and reassures patient of continuing care.*

8. Refer patient and family or significant other to psychiatric liaison nurse, support group, or other resources, as appropriate. *Community resources often provide health care not available from other health agencies.*

Documentation

- Observations of urologic condition and patient's response to treatment regimen
- Interventions to provide supportive care
- Patient's response to nursing interventions
- Instruction given to patient and family or significant other on urologic problem, their response to instructions, and their demonstrated ability to carry out self-care management
- Patient's expression of concern about the urologic problem and its impact on body image and life-style; patient's motivation to participate in self-care
- Evaluations for each expected outcome.

Care plan notes

Care plan notes

Infant feeding pattern, ineffective

related to neurologic impairment or developmental delay

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Definition

Impaired ability of an infant to suck or coordinate the suck-and-swallow response

Assessment

- Perinatal history, including gestational age and Apgar score
- Suck and swallow reflex, including condition of lip and palate
- Nutritional status, including intake (type, amount, and frequency of feedings), output (frequency, amount and characteristics of urine), current weight, weight change since delivery, skin turgor, signs of dehydration
- Laboratory studies, including glucose and bilirubin levels
- Parental assessment, including age, maturity level, previous experience with infant feeding

Defining characteristics

- Inability to coordinate sucking, swallowing, and breathing
- Inability to initiate or sustain an effective suck

Associated medical diagnoses (selected)

Cleft lip, cleft palate, microcephaly, neonatal anomaly, neurologic impairment, prematurity

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Neonate does not lose more than 10% of birth weight within first week of life. (1,9,13)
- Neonate gains 4 to 7 ounces per week after the first week of life. (1,9)
- Factors which interfere with the neonate establishing an effective feeding pattern are identified. (2,17)
- Parents express increased confidence in their ability to perform appropriate feeding techniques. (3,4,5,6,7,8)
- Neonate does not experience dehydration. (12,13)
- Neonate receives adequate supplemental nutrition until able to suckle sufficiently. (9,14,15,16)
- Neonate establishes effective suck and swallow reflexes which allow for an adequate intake of nutrients. (2,10,11,17)

Interventions and rationales

1. Using the same scale, weigh neonate at same time each day *to ensure early recognition of excessive weight loss.*
2. Continuously assess neonate's sucking pattern *to monitor for ineffective patterns.*

3. Assess parents' knowledge of feeding techniques *to help identify and clear up misconceptions.*

4. Assess parents' level of anxiety with regard to neonate's feeding difficulty. *Anxiety may interfere with parents' ability to learn new techniques.*

5. Remain with parents and neonate during feeding *to identify problem areas and direct interventions.*

6. Teach parents to place neonate in upright position during feeding *to prevent aspiration.*

7. Teach parents to unwrap and position a sleepy neonate before feeding *to ensure that infant is awake and alert enough to suckle sufficiently.*

8. Provide positive reinforcement for parents' efforts to improve feeding technique *to decrease anxiety and enhance feelings of success and self-esteem.*

9. For bottle-feeding, record amount ingested at each feeding. For breastfeeding, record number of minutes neonate nurses at each breast, and amount of any supplement ingested *to monitor for inadequate caloric and fluid intake.*

10. Provide an alternative nipple, such as a premie nipple. *A premie nipple has a larger hole and softer texture which make it easier for neonate to obtain formula.*

11. For breastfeeding, ensure neonate's tongue is properly positioned under mother's nipple *to facilitate adequate sucking.*

12. Monitor neonate for poor skin turgor, dry mucous membranes, decreased or concentrated urine, sunken fontanels and eyeballs *to detect possible dehydration. Initiate immediate intervention to ensure neonate's well-being.*

13. Record number of stools and amount of urine voided each shift. *Altered bowel elimination pattern may indicate decreased food intake; decreased amounts of concentrated urine may indicate dehydration.*

14. Assess need for gavage feeding. *Neonate may require a temporary, alternative means of obtaining adequate fluids and calories.*

15. Alternate oral and gavage feeding *to conserve neonate's energy.*

16. If intravenous nourishment is necessary, assess the insertion site, amount infused, and infusion rate every hour *to monitor fluid intake*

(continued)

† Numbers following outcomes refer to interventions.

Infant feeding pattern, ineffective related to neurologic impairment or developmental delay

77b

Interventions and rationales (continued)

and identify complications associated with intravenous therapy, such as infiltration and phlebitis.

17. Assess neonate for neurologic deficits or other pathophysiologic causes of ineffective sucking *to identify the need for more extensive evaluation.*

Documentation

- Frequency, amount, and type of fluid ingested by neonate
- Effectiveness of suck reflex
- Neonate's daily weight
- Parents' knowledge of feeding techniques, involvement with caretaking, and bonding with neonate
- Frequency of bowel elimination and urination
- Signs of dehydration
- Nursing interventions and neonate's response

Care plan notes

- Use of special feeding techniques and equipment
- Laboratory data
- Parents' and neonate's responses to nursing interventions
- Evidence of neurologic or other physical impairment in neonate
- Evaluations for each expected outcome.

Care plan notes

Definition

Presence of internal or external hazards that threaten physical well-being

Assessment

- Health history, including accidents, allergies, falls, hyperthermia, hypothermia, poisoning, seizures, trauma, exposure to pollutants
- Sensory or perceptual changes (auditory, gustatory, kinesthetic, olfactory, tactile, visual)
- Circumstances of present situation that could lead to infection
- Neurologic status, including level of consciousness, mental status, orientation
- Laboratory studies, including clotting factors, hemoglobin and hematocrit, platelet count, serum albumin, white blood cell count, and cultures of blood, body fluid, sputum, urine, wounds

Risk factors

- Admission to hospital
- Age (over 65)
- Chemotherapy
- Hemodialysis
- Hospitalized longer than 1 month
- Immobility
- Indwelling urinary catheter
- Intravenous catheter
- Invasive monitoring procedures
- Obesity
- Prophylactic antibiotic therapy
- Respiratory treatments (endotracheal or tracheostomy tube, humidifier or nebulizer, ventilator)
- Steroid therapy
- Surgical procedure

Associated medical diagnoses (selected)

Although any patient can develop a nosocomial infection, debilitated, elderly, and postoperative patients (especially transplantation patients) are at greatest risk. Associated medical diagnoses include acquired immunodeficiency syndrome, acute renal failure, acute respiratory failure, cancer, cirrhosis, congestive heart failure, diabetes mellitus, hepatitis, multiple sclerosis, multisystem trauma, spinal cord injury.

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Temperature stays within normal range. (2)
- White blood cell count and differential stay within normal range. (3)
- No pathogens appear in cultures. (4)
- Patient maintains good personal and oral hygiene. (5,6,8)
- Respiratory secretions are clear and odorless. (9,12,13,15)
- Urine remains clear yellow, odorless, with no sediment. (9)
- Patient shows no evidence of diarrhea. (7)
- Wounds and incisions appear clean, pink, and free of purulent drainage. (9)
- I.V. sites show no signs of inflammation. (9,10,11)
- Patient shows no evidence of skin impairment. (14)
- Patient takes _____ ml of fluid and _____ g of protein daily. (16,17)
- Patient states infection risk factors. (19)
- Patient identifies signs and symptoms of infection. (19)
- Patient remains free of all signs and symptoms of infection. (1-19)

Interventions and rationales

1. Minimize patient's risk of infection by:
 - a. washing hands before and after providing care. *Handwashing is the single best way to avoid spreading pathogens.*
 - b. wearing gloves to maintain asepsis when providing direct care. *Gloves offer protection when handling wound dressings or carrying out various treatments.*
2. Monitor temperature at least every 4 hours and record on graph paper. Report elevations immediately. *Sustained temperature elevation after surgery may signal onset of pulmonary complications, wound infection or dehiscence, urinary infection, or thrombophlebitis.*
3. Monitor white blood cell count, as ordered. Report elevations or depressions. *Elevated total white blood cells indicate infection. Markedly decreased white blood cells may indicate decreased production resulting from extreme debilitation or severe lack of vitamins and amino acids. Any damage to bone marrow may suppress white blood cell formation. ‡*
4. Culture urine, respiratory secretions, wound drainage, or blood according to hospital policy

and doctor's order. *This identifies pathogens and guides antibiotic therapy. ‡*

5. Help patient wash hands before and after meals and after using the bathroom, bedpan, or urinal. *Handwashing prevents spread of pathogens to other objects and food.*
6. Assist patient when necessary to ensure that the perianal area is clean after elimination. *Cleaning perineal area by wiping from area of least contamination (urinary meatus) to area of most contamination (anus) helps prevent genitourinary infections.*
7. Instruct the patient to report incidents of loose stools or diarrhea. Inform the doctor immediately. *Loose stools or diarrhea may indicate the need to discontinue or change antibiotic therapy. They may also indicate the need to test for Clostridium difficile.*
8. Offer oral hygiene to the patient every 4 hours to prevent colonization of bacteria and reduce the risk of descending infection. *Disease and malnutrition may reduce moisture in mucous membranes of mouth and lips.*
9. Use strict aseptic technique when suctioning the lower airway, inserting indwelling uri-

(continued)

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Interventions and rationales (continued)

nary catheters, inserting I.V. catheters, and providing wound care *to avoid spreading pathogens.*

10. Change I.V. tubing and give site care every 24 to 48 hours or as hospital policy dictates *to help keep pathogens from entering the body.*

11. Rotate I.V. sites every 48 to 72 hours or as hospital policy dictates *to reduce chances of infection at individual sites.*

12. Have patient cough and deep-breathe every 4 hours after surgery *to help remove secretions and prevent pulmonary complications.*

13. Provide tissues and disposal bag for expectorated sputum. *Convenient disposal encourages expectoration; sanitary disposal reduces spread of infection.*

14. Help patient turn every 2 hours. Provide skin care, particularly over bony prominences, *to help prevent venous stasis and skin breakdown.*

15. Use sterile water for humidification or nebulization of oxygen. *This prevents drying and irritation of respiratory mucosa, impaired ciliary action, and thickening of secretions within respiratory tract.*

16. Encourage fluid intake of 3,000 to 4,000 ml daily, unless contraindicated, *to help thin mucous secretions.*

17. Ensure adequate nutritional intake. Offer high-protein supplements unless contraindicated. *This helps stabilize weight, improves muscle tone and mass, and aids wound healing.*

18. Arrange for reverse isolation if patient has compromised immune system. Monitor flow and number of visitors. *These measures protect patient from pathogens in the environment.*

19. Educate the patient regarding:
a. good handwashing technique
b. factors that increase infection risk
c. infection signs and symptoms.

These measures allow patient to participate in care and help patient modify life-style to maintain optimum health level.

Documentation

- Temperature
- Dates, times, and sites of all cultures
- Dates, times, and sites of all catheter insertions
- Appearance of all invasive catheter sites, tube sites, and wounds
- Interventions performed to reduce infection risk
- Patient's response to nursing interventions
- Evaluations for each expected outcome.

Care plan notes

Definition

Accentuated risk of invasion of a surgical wound by a pathogenic organism (bacteria, virus, fungus, protozoa, parasite) from either endogenous or environmental sources

Assessment

- Age
- Sex
- Weight
- Reason for surgery
- Type of surgery
- Current health status, including vital signs, temperature, nutritional status, integumentary status
- Laboratory studies, including hematocrit and hemoglobin, complete blood count, electrolytes, urinalysis, blood cultures, blood coagulation studies, immunologic and serologic tests, liver function tests
- Presence of infection (urinary, respiratory, oral)

- Health history, including drug allergies, recent infection, substance abuse, chronic metabolic or systemic disease (diabetes mellitus; cardiovascular, hepatic, or renal disease; coagulation disorders; splenic or bone marrow disorders)
- Mobility status
- Anticipated length of surgery
- Current medical treatments, including radiation therapy, chemotherapy, antibiotic or antifungal therapy, steroid treatment, anticoagulant or thrombolytic therapy, immunosuppressive therapy
- Presence of invasive devices, including Foley catheter, endotracheal tube, tracheostomy tube, I.V. lines, central venous and arterial lines, drains, gastric feeding tubes
- Wound classification (clean, clean-contaminated, contaminated, dirty)

Risk factors

- Altered immune function
- Chronic illness
- Immobility
- Impaired cardiovascular functioning leading to decreased oxygen transport
- Malnutrition
- Substance abuse

Associated medical diagnoses (selected)

Acquired immunodeficiency syndrome, anemia, blood dyscrasia, cancer, cardiovascular disease, chronic obstructive pulmonary disease, diabetes mellitus, emphysema, hepatitis, leukemia, liver cirrhosis, malnutrition, multiple myeloma, open wounds or lesions, peripheral vascular disease, portal hypertension, rheumatoid arthritis, substance abuse, systemic lupus erythematosus, thrombocytopenia

Expected outcomes †

- Vital signs, temperature, and laboratory values remain within the patient's normal limits. (1,8,9,10,13,16)
- Incision site remains free of signs and symptoms of infection. (2,3,4,5,6,7,8,9,10,12,14,15,16)
- Dehiscence does not occur. (11,16)

Interventions and rationales

1. Document and report results of preoperative nursing assessment. Identify risk factors predisposing the patient to infection. *A complete nursing assessment allows development of an individualized care plan.*
2. Make sure all surgical team members wear appropriate operating room (OR) attire. *The human body is a major source of microbial contamination.*
3. Inspect the OR for cleanliness before opening supplies and instruments *to provide a safe environment.*
4. Perform a surgical hand scrub. Put on sterile gown and gloves. Place sterile drapes on the patient, furniture, and equipment. *The surgical hand scrub minimizes the number of mi-*

croorganisms on the skin. Sterile gown and gloves protect against contamination. Sterile drapes create the sterile field.

5. Check the package integrity, chemical indicator, and, if appropriate, the expiration date on all sterile items before dispensing them onto the sterile field. *All items used within the field must be sterile.*
6. Closely monitor the sterile field and initiate corrective measures when a break in technique occurs. *Contamination of the sterile field may lead to wound contamination and subsequent infection.*
7. Use proper technique when opening items onto the sterile field *to avoid contamination.*
8. Perform preoperative skin preparation of the surgical site. *Skin preparation reduces the resident microbial count to subpathogenic amounts and inhibits rapid rebound growth of microbes.*
9. Keep OR doors closed at all times and minimize traffic in and out. *Air turbulence caused by movement and the mixing of corridor air with room air can sharply increase OR bacterial counts.*
10. Maintain room temperature of 68° to 75° F

(20° to 23.9° C) and the relative humidity at 50% ± 10, unless contraindicated. *Cooler air temperature and lower humidity inhibit microbial growth.*

11. Classify the surgical wound according to the degree of contamination of the wound and surrounding tissue. *Classification helps to assess the risk of wound infection from an endogenous source and determine the need for antibiotic therapy.*

12. Wash hands following contact with the patient or any object contaminated with blood or body fluids. *Handwashing is the most effective means for preventing microbial transmission.*

13. Administer antibiotics, as ordered. *Intraoperative administration of antibiotics can decrease the incidence of wound infection and lessen its severity. ‡*

14. Disinfect and sterilize all instruments and equipment before and immediately after the surgical procedure. *All instruments and equipment used during surgery must be free of microorganisms. Sterilizing instruments and equipment after use prevents growth and spread of microorganisms during storage.*

(continued)

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Interventions and rationales (continued)

15. Promptly clean areas outside the sterile field that become contaminated by blood, tissue, or body fluids with an approved disinfectant *to prevent the distribution of microbes into the environment.*

16. Apply sterile dressing to the surgical wound before removing the surgical drapes *to avoid wound contamination and subsequent infection.*

- Intraoperative insertion of permanent or temporary implants
- Type of wound closure method
- Type of dressing applied
- Estimated intraoperative blood loss
- Evaluations for each expected outcome.

Care plan notes

Documentation

- Results of preoperative nursing assessment
- Operative procedure
- Type of anesthesia
- Surgical times (time patient entered OR, time incision was made, time incision was closed, time patient left OR)
- Wound classification
- Intraoperative administration of antibiotics
- Presence of packing, drains, Foley catheter, or other invasive devices

Care plan notes

Definition

Accentuated risk of physical harm caused by lack of awareness of dangers in the environment

Assessment

- Age
- Health history, including accidents, falls, exposure to environmental hazards
- Environmental factors, including household layout, electrical wiring, lighting, utilities, fire precautions, presence of toxic or noxious substances, medications, special safety needs, childproofing
- Mental status, including mood, affect, thought processes, thought content, orientation, judgment, ability to perform activities of daily living
- Knowledge, including understanding of household safety precautions, automobile safety

- Participation in recreational activities, such as swimming, diving, motorcycling, bicycling, contact sports

Risk factors

- Access to poisons or toxins
- Age (infant, child, over 65)
- Evidence of environmental hazards
- History of household or automobile accidents
- Improper use of toys
- Lack of knowledge of environmental hazards
- Lack of knowledge of household safety precautions

Associated medical diagnoses (selected)

Burns, inhalation injuries, poisoning, psychiatric disorders, suffocation, trauma

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient and family acknowledge presence of environmental hazards in their everyday surroundings. (1,4)
- Patient and family practice safety and take safety precautions in the home. (2)
- Adults in household instruct children in safety habits. (3)
- Adults in household childproof the house to ensure safety of young children and cognitively impaired adults. (2,4)

Interventions and rationales

1. Help patient identify situations and hazards that can cause accidents *to increase the patient's awareness of potential dangers.*
2. Encourage patient to make repairs and remove potential safety hazards from the environment *to decrease the possibility of injury.*
3. Encourage adults to discuss safety rules with children, for example:
 - a. Don't play with matches.
 - b. Use electrical equipment carefully.
 - c. Know location of fire escape route.
 - d. Don't speak to strangers.
 - e. Dial 911 in an emergency.

Teaching by parents fosters household safety.

4. Refer patient to appropriate community resources for more information about identifying and removing safety hazards. *This enables patient and family to alter environment to achieve optimal safety level.*

Documentation

- Patient's statements about situations that cause accidents and injuries
- Patient's lack of awareness of, or disregard for, safety hazards
- Patient's cognitive deficits that inhibit learning or attention to safety hazards
- Interventions to help patient recognize and eliminate safety hazards
- Patient's or family's response to nursing interventions
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

Definition

Accentuated risk of physical harm caused by sensory or motor deficits

Assessment

- Age
- Nature of sensory or motor deficit
- Health history, including cerebral function, mobility, sensory function, use of adaptive devices
- Psychological status, including substance abuse, familiarity with surroundings, mental status, coping skills, self-concept
- Medication use, including understanding of medications, compliance with prescribed regimen, use of over-the-counter medications, interactions
- Knowledge, including understanding of safety precautions
- Medication history
- Pain or fatigue
- Laboratory studies, including complete blood

count and differential, coagulation studies

- Diagnostic tests, including chest X-ray, cranial X-ray
- Sensory status, including hearing, vision, touch, taste

Risk factors

- Brain injury
- Contractures
- Developmental disability
- History of accidents (falls, burns, cuts, bruises, scrapes)
- Impaired mobility (immobilization, limited or restricted movement, pain with movement, vertigo)
- Inflamed joints
- Injuries in various stages of healing
- Misuse of adaptive devices or equipment (wheelchairs, crutches, walkers, grabbers, canes)
- Muscle spasticity
- Paralysis

- Paresis
- Polypharmacy or medication overdose
- Sensory deficits (decreased or absent vision, hearing, thermal perception)
- Skeletal deformities
- Substance abuse
- Unsteady gait

Associated medical diagnoses (selected)

Cardiac disorders, blindness, deafness, hallucinations, hematologic disorders, limb amputation, muscular disorders, neural disorders, organic brain syndrome, posttraumatic head injury (closed head injury), pulmonary disorders, skeletal disorders, syncope, tinnitus, tissue hypoxemia or hypoperfusion, vertigo

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient identifies factors that increase potential for injury. (1,3)
- Patient assists in identifying and applying safety measures to prevent injury. (2)
- Patient and family or significant other develop strategy to maintain safety. (3)
- Patient optimizes activities of daily living within sensorimotor limitations. (2)

Interventions and rationales

1. Observe for factors that may cause or contribute to injury *to increase awareness of patient, significant other, and caregivers.*
2. Improve environmental safety, as needed:
 - a. Orient patient to environment. Assess patient's ability to use call bell, side rails, and bed positioning controls. Keep bed at lowest level and conduct close night watch. *These measures will help patient cope with unfamiliar surroundings.*
 - b. Teach patient and family about need for safe illumination. Advise patient to wear sunglasses to reduce glare. Advise using contrast colors in household furnishings.

These measures will enhance visual discrimination.

- c. Test heating pads and bath water before using; assess extremities daily for injury *to assist patient with decreased tactile sensitivity.*
 - d. For the patient with hearing loss, encourage use of hearing aid *to minimize deficit.*
 - e. Teach patient with unstable gait correct use of adaptive devices *to decrease potential for injury.*
3. Provide additional patient teaching as needed. Possible topics may include household, automobile, and pedestrian safety. Refer patient to appropriate resources (police, fire, home health care association) for more information. *Health education can help patient take steps to prevent injury.*

Documentation

- Statements by patient and family or significant other about potential for injury due to sensory or motor deficits
- Manifestations of deficit
- Observation or knowledge of unsafe practices

- Interventions to decrease risk of injury to patient
- Patient's responses to nursing interventions
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

Definition

Accentuated risk of tissue injury, neuromuscular impairment, vascular compromise, or impaired gas exchange during surgery

Assessment

- Reason for surgery
- Type of surgery and its expected length
- Health status, including age, weight, vital signs, nutritional status, integumentary status, musculoskeletal status, hydration status, temperature, peripheral vascular status, neurologic status, smoking history
- Laboratory studies, including hematocrit and hemoglobin, complete blood count, electrolytes, urinalysis, blood coagulation studies, liver function tests
- Mobility status, including range of motion; presence of prosthesis; limb abnormality, impairment, or injury
- Current medical treatments, including radiation therapy, chemotherapy, steroid therapy

Risk factors

- Altered circulation or sensation
- Altered metabolic or nutritional state (obesity, emaciation)
- Anesthesia (general, regional)
- Bony prominences
- Broken skin
- Cardiovascular, hepatic, renal, or respiratory disease; diabetes mellitus; musculoskeletal disorders
- Edema
- Extended surgery
- Hypovolemia
- Immobility
- Mechanical factors, including friction, pressure, or shearing force

Associated medical diagnoses (selected)

Any disease that may require surgery.

Supine position: Abdominal aortic aneurysm resection, appendectomy, arthroscopy, arthrothomy, bowel resection, bronchoscopy, cholecystectomy, colostomy, coronary artery bypass grafting, cystectomy, exploratory laparotomy, gastrectomy, hernia repair, ileal conduit, mediastinoscopy, splenectomy, total abdominal hysterectomy, pacemaker insertion, rotator cuff repair

Prone position: Achilles tendon repair, anal fissurectomy or fistulectomy, hemorrhoidectomy, laminectomy (thoracic, lumbar), pilonidal cyst excision, posterior cervical fusion, spinal fusion with Harrington rods

Lateral position: Descending thoracic aortic aneurysm resection, nephrectomy, nephrolithotomy, thoracotomy, total hip arthroplasty

Lithotomy position: Anterior or posterior vaginal repair, conization of the cervix, dilata-

(continued)

Associated medical diagnoses (cont'd.)

tion and curettage, hemorrhoidectomy and other rectal procedures, laparoscopy, laser vaporization, perineal condyloma, low anterior bowel resection, rectovaginal or vesicovaginal fistulectomy, total vaginal hysterectomy, uterine or bladder suspension

Expected outcomes †

- Patient maintains effective breathing patterns and adequate cardiac output. (1,5,6)
- Patient shows no evidence of tissue injury, neuromuscular impairment, or vascular compromise. (1,2,3,4,5,6,7)

Interventions and rationales

1. Document and report results of preoperative nursing assessment. Identify factors predisposing the patient to pressure tissue injury. *This information guides interventions.*
2. Use appropriate mode of patient transportation (stretcher, patient bed, wheel chair, crib) *to ensure patient safety.*
3. Make sure an adequate number of staff assist with transferring patient. A minimum of two staff are needed for moving the patient

onto the operating room (OR) bed. A minimum of four staff are needed for moving the anesthetized patient off the OR bed. *Adequate staffing enhances safety.*

4. Check the OR bed preoperatively for proper functioning. *Intraoperative bed malfunction can result in increased anesthesia time and a more difficult surgical approach.*

5. Ensure proper positioning.

Supine:

- a. Check alignment of neck and spine.
- b. Check that legs are straight and uncross ankles. *Crossed ankles cause pressure on tissue, vessels, and nerves.*
- c. Place safety strap 2 inches above the knees, tight enough to restrain without compromising superficial venous return. *Applied too tightly, safety strap may cause venous thrombosis or compression of the tibial, peroneal, or sciatic nerves.*
- d. Secure arms at sides with draw sheet, palms down, making sure no part of arm or hand extends over mattress. Alternatively, secure arms on padded arm boards at less than 90 degree angle from body, palms supinated. *Hyperextension*

can cause injury to the brachial plexus. Supination of palms minimizes pressure.

- e. Apply eye pads if eyelids will not remain closed or if surgery is being performed on head, neck, or chest. *If allowed to remain open, the eye may dry out and become infected. Corneal abrasions may result from drapes and other foreign material rubbing against eye.*
- f. If surgery is expected to last more than 2 hours or if patient is predisposed to pressure injury, place padding under occiput, scapulae, olecranon, sacrum, coccyx, and calcaneus *to protect potential pressure points.* Apply a padded foot board *to support the feet, avoid plantar flexion, and prevent stretching of the tibial nerve and subsequent foot drop.*
- g. Unless contraindicated, place a foam doughnut or small pillow under head *to prevent stretching of the neck muscles.*

Prone:

- a. Make sure at least four staff members assist when turning the patient *to assure safety.*

(continued)

† Numbers following outcomes refer to interventions.

Interventions and rationales (continued)

- b. Place a foam doughnut or small pillow under head. Check lower eye and ear for excessive pressure. Apply eye pads. *Head support assists in maintaining cervical and thoracic spine alignment. Checking dependent ear and eye lowers risk of pressure injury. Pads protect eyes.*
- c. Place arms on armboards extended in front beside head with elbows slightly flexed and palms pronated *to prevent strain on shoulder, elbows, and wrist joints.*
- d. Check for proper alignment of neck and spine.
- e. Check female patient's breasts and male patient's genitalia for excessive pressure from chest rolls or laminectomy brace *to avoid soft tissue and nerve injury.*
- f. Check bilateral pulses of upper and lower extremities. *Top and bottom edges of chest rolls or laminectomy brace may*

compress radial and femoral arteries.

- g. Place padding under knees *to avoid injury to soft tissue and knee joint.*
- h. Place a pillow under ankles *to avoid putting pressure on toes and feet, stretching the tibial nerve, or causing plantar flexion.*
- i. Place safety strap 2" above the knees, securely but not too tightly *to restrain patient without compromising superficial venous return.*
- j. If surgery is expected to last more than 2 hours or if patient is predisposed to pressure injury, place padding under acromion process, olecranon, and anterior iliac spine *to protect pressure points.*

Lateral:

- a. Make sure at least four staff members assist when turning patient *to assure safety.*
- b. Check neck and spine for proper alignment.
- c. Place a foam doughnut or small pillow

under patient's head. Check dependent eye and ear for excessive pressure. Apply eye pads. *Head supports assist in maintaining cervical and thoracic spine alignment. Checking dependent ear and eye lowers risk of pressure injury. Pads protect patient's eyes.*

- d. Place a small roll under dependent lower axilla *to relieve pressure on the chest and axilla, allow for adequate chest expansion, and prevent compression of the brachial plexus by the humeral head.*
- e. Place lower arm on arm board less than 90 degree angle from body, palm supinated. Place upper arm on an elevated padded support, less than 90 degree angle from body, palm pronated, and apply restraints *to avoid injury to the brachial plexus.*
- f. Place bottom leg flexed at the hip and knee and the top leg straight. *Flexing the*

(continued)

Interventions and rationales (continued)

bottom leg provides greater stability for the torso, decreases the pressure on the lateral aspect of lower leg, and prevents the bony areas of the knees and ankles from pressing against each other.

- g. Place pillows between knees and ankles to support the top leg, prevent strain on the top hip, and pad pressure points on medial aspects of both legs.
- h. Place padding under lateral aspects of bottom knee and ankle to reduce risk of tissue injury to the area over the lateral malleolus of the ankle and peroneal nerve damage (foot drop).
- i. Place safety strap across upper thighs or wide tape over hips. Attach strap or tape to bed to assure safety.
- j. If surgery is expected to last more than 2 hours or if patient is predisposed to pressure injury, place padding under acromion process, ilium, and greater trochanter to protect pressure points.

Lithotomy:

- a. Secure arms on armboards or at sides. If arms are placed at sides, position fingers

away from the break in the table to prevent fingers from becoming compressed in bed mechanism.

- b. Check neck and spine for proper alignment.
- c. Position stirrups at equal height and attach them to bed securely to prevent accidental movement. Uneven leg flexion and hip abduction can cause strain on lumbar and sacral areas.
- d. Place the loop straps of post stirrup behind the ankle and under the foot. Pad the post portion of stirrup if it could come in contact with the leg. Loop straps support and secure the legs.
- e. Pad popliteal knee support stirrups to prevent possible thrombosis of superficial vessels and pressure injury to the femoral and obturator nerves.
- f. If surgery is expected to last more than 2 hours or if patient is predisposed to pressure injury, place padding under occiput, scapulae, olecranon, and sacrum to protect potential pressure points.
- g. With the help of a coworker, raise and lower patient's legs simultaneously and

slowly to prevent ankle and knee injury and hip dislocation. Lowering the legs too quickly may cause sudden hypotension.

6. Assess patient position following each positional change to ensure proper body alignment and adequate padding and support.

7. Apply restraints after positioning patient to prevent falls and injury.

Documentation

- Results of preoperative nursing assessment
- Operative procedure, type of anesthesia, and surgical positioning
- Surgical times, including time patient entered OR, time incision was made, time incision was closed, time patient left OR
- Method of patient transport and transfer
- Estimated intraoperative blood loss
- Types and placement of padding, restraints, and positional devices
- Intraoperative repositioning of the patient
- Intraoperative insertion of permanent or temporary implants
- Peripheral pulses
- Evaluations for each expected outcome.

Definition

Inadequate understanding of information or inability to perform skills needed to practice health-related behaviors

Assessment

- Psychosocial status, including age, learning ability (affective domain, cognitive domain, psychomotor domain), decision making, developmental stage, financial resources, interest in learning, knowledge and skills related to current health problem, obstacles to learning, support systems (willingness and capability of others to help client), usual coping pattern
- Neurologic status, including level of consciousness, memory, mental status, orientation

Defining characteristics

- Cognitive impairment
- Inaccurate follow-up on previous instruction
- Inadequate performance of a test or demonstration of a skill
- Inappropriate or exaggerated behaviors (hysteria, hostility, agitation, apathy)
- Patient's statements indicating insufficient recall of information, poor understanding, misinterpretation, or misconception

Associated medical diagnoses (selected)

Alzheimer's disease, brain tumor, cerebrovascular accident, head injury, mental retardation, organic brain syndrome

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient demonstrates ability to perform simple self-care measures, such as feeding, maintaining hygiene, dressing, toileting. (1,2,3)
- Family or significant other communicates understanding of patient's cognitive impairment. (4,5,6)
- Family or significant other expresses willingness to help patient maintain maximum independence. (7,8)
- Family or significant other demonstrates method being used to teach patient. (7,8)

Interventions and rationales

1. Provide all equipment needed for each self-care measure patient must learn. *This reduces frustration, aids learning, and minimizes dependence by promoting self-care.*
2. When teaching self-care measures, go slowly and repeat frequently. Offer small amounts of information and present it in various ways. *By building cognition, patient will be better able to complete self-care measures.*
3. Have patient practice each task. Provide positive reinforcement each time task is per-

formed correctly. *This encourages desired behavior.*

4. Discuss patient's limitations with family or significant other. *Communication promotes working relationship and reduces fear and anxiety.*
5. Demonstrate to family or significant other how each self-care measure is broken down into simple tasks *to enhance patient's success and foster sense of control.*
6. Encourage family or significant other to participate in patient's learning process *to help create an encouraging, therapeutic climate after discharge.*
7. Have family or significant other give return demonstration of patient's methods of performing self-care measures. *This provides hands-on experience with equipment, builds confidence, and encourages compliance.*
8. Refer family or significant other to outside agencies, such as a home health care organization, for assistance after patient's discharge. *This ensures continuity of care and assistance with follow-up after discharge.*

Documentation

- Patient's abilities and limitations in performing self-care measures
- Progress made by patient in learning each specific task
- Information imparted to family or significant other concerning patient's limitations and progress in learning tasks
- Family's or significant other's participation in the learning process
- Referrals to outside agencies
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

Definition

Inadequate understanding of information or inability to perform skills needed to practice health-related behaviors

Assessment

- Psychosocial status, including age, learning ability (affective domain, cognitive domain, psychomotor domain), decision making ability, developmental stage, financial resources, health beliefs and attitudes, interest in learning, knowledge and skill regarding current health problem, obstacles to learning, support systems (willingness and capability of others to help patient), usual coping pattern
- Neurologic status, including level of consciousness, memory, mental status, orientation

Defining characteristics

Patient's requests for information, expressions of problem, and lack of familiarity with informational resources

Associated medical diagnoses (selected)

This nursing diagnosis can occur in association with any medical diagnosis

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient communicates a need to know. (1)
- Patient states or demonstrates understanding of what has been taught. (4)
- Patient demonstrates ability to perform new health-related behaviors as they are taught, and lists specific skills and realistic target dates for each. (5)
- Patient sets realistic learning goals. (2,3)
- Patient states intention to make needed changes in life-style, including seeking help from health professional when needed. (5,6)

Interventions and rationales

1. Establish an environment of mutual trust and respect to enhance learning. *Comfort with growing self-awareness, ability to share this awareness with others, receptiveness to new experiences, and consistency between actions and words form the basis of a trusting relationship.*
2. Negotiate with patient to develop goals for learning. *Involving patient in planning meaningful goals encourages follow-through.*
3. Select teaching strategies (discussion,

demonstration, role-playing, visual materials) appropriate for patient's individual learning style (specify), *to enhance teaching effectiveness.*

4. Teach skills that patient must incorporate into daily life-style. Have patient give return demonstration of each new skill *to help gain confidence.*

5. Have patient incorporate learned skills into daily routine during hospitalization (specify skills). *This allows patient to practice new skills and receive feedback.*

6. Provide patient with names and telephone numbers of resource people or organizations *to provide continuity of care and follow-up after discharge.*

Documentation

- Patient's statements of information and skills known or unknown
- Expressions of need to know, motivation to learn
- Learning objectives
- Methods used to teach patient
- Information imparted

- Skills demonstrated
- Patient's responses to teaching
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

Definition

Inadequate understanding of information or inability to perform skills needed to practice health-related behaviors

Assessment

- Psychosocial status, including age, learning ability (affective domain, cognitive domain, psychomotor domain), decision-making, developmental stage, financial resources, interest in learning, knowledge and skills related to current health problem, obstacles to learning, support systems (willingness and capability of others to help patient), usual coping pattern
- Neurologic status, including level of consciousness, memory, mental status, orientation

Defining characteristics

- Behavior that indicates failure to adhere
- Failure to learn new skills
- Inaccurate follow-up of instruction
- Inappropriate or exaggerated behavior
- Unwillingness to set goals

Associated medical diagnoses (selected)

This nursing diagnosis may coincide with any medical diagnosis but most commonly accompanies chronic diseases requiring major changes in health-related behaviors or lifestyle, such as cardiovascular disease, chronic obstructive pulmonary disease, diabetes mellitus, hypertension, and mental retardation.

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient expresses interest in learning new behaviors. (1,2,3)
- Patient gradually sets realistic learning objectives (specify). (4,5,6,7)
- Patient strives to meet each objective by target date. (8)
- Patient practices new health-related behaviors during hospitalization; for example, selects appropriate diet, self-medicates, weighs self daily, monitors intake and output. (9,10)
- Patient develops realistic plan for maintaining new skills at home. (11)

Interventions and rationales

1. Provide uninterrupted time for patient to state reasons for not wanting to learn or practice new health-related behaviors. *Attentive listening conveys caring attitude, encouraging patient to talk.*
2. Avoid nonconstructive criticism. Rather, encourage expression of feelings. *Nonjudgmental approach encourages patient to express feelings more freely.*
3. Ascertain what patient already knows to determine what patient needs to know. *Building*

on known information leads to successful learning.

4. Explore with patient the impact of behavior on self and family or significant other. *Learning is more effective if patient recognizes a need to know.*
5. Urge patient to ask questions to help clarify information and evaluate patient's comprehension.
6. Determine whether patient enjoys learning through such media as videotapes, audiotapes, books, and discussions to discover most effective teaching tools.
7. Begin negotiating learning objectives with patient. *Involving patient in defining goals increases understanding and encourages compliance.*
8. Be patient; offer praise when patient attempts new behaviors to motivate patient to learn more.
9. Provide emotional support as patient attempts distasteful or anxiety-producing behaviors. *Support will help patient perform tasks successfully.*
10. Suggest that patient discuss situation with a person who has developed skill in managing

a similar health problem to encourage patient to air feelings and concerns.

11. Help patient plan realistically for continuing new behaviors, which may include teaching family or significant other. *Realistic goals increase probability of compliance. Involving others adds support after discharge.*

Documentation

- Statements of motivation or lack of interest in learning
- Observations that indicate readiness or lack of readiness to learn
- Goals set by patient
- Methods used to teach patient
- Information imparted
- Skills demonstrated
- Patient's responses to trying new behaviors
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

Definition

Inadequate understanding of safer sexual practices, which puts the patient and partner at risk for human immunodeficiency virus (HIV) infection and other sexually transmitted diseases

Assessment

- Psychosocial status, including age, experience, learning ability, decision-making abilities (especially in sexual relationships), developmental stage, support systems (partner, friends, family), obstacles to learning
- Neurologic status, including level of consciousness, memory, mental status, orientation
- Substance abuse, including alcohol, medications, illicit drugs, I.V. drugs
- Sexuality status, including sexual orientation and current sexual practices

Defining characteristics

- Behavior that may impair ability to make appropriate decisions about sexual activity, such as drug or alcohol use
- Inability to negotiate for safer sex practices in a relationship
- Lack of knowledge about the relative risk of various sexual practices
- Sexual behavior that puts self or partner at risk

Associated medical diagnoses (selected)

Acquired immunodeficiency syndrome (AIDS), chancroid, *Chlamydia* infection, genital herpes, genital warts, gonorrhea, HIV infection, syphilis, trichomoniasis

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient expresses the understanding that certain sexual practices heighten the risk for disease transmission. (1,2,3,4)
- Patient expresses an understanding of safer sexual practices. (2,3,6,8)
- Patient states the intention to incorporate safer sexual practices into life-style. (4,5,9,10)
- Patient states the intention to negotiate the sexual boundaries of relationship with the partner. (4,5,6,7)

Interventions and rationales

1. Using a nonjudgmental approach, assess the patient's sexual practices and awareness of risks associated with various sexual behaviors *to target your teaching plan*.
2. Explain the degree of risk associated with specific sexual activities:
 - a. *High-risk activities:* Anal intercourse without a condom, manual anal intercourse (fisting), vaginal intercourse without a condom, unprotected oral sex on a male (fellatio) or female (cunnilingus), oral-anal contact (rimming), blood contact, urine or semen ingestion.

- b. *Moderate-risk activities:* French (wet) kissing, anal or vaginal intercourse (with nonoxynol 9 latex condom), fellatio interruptus (oral-genital) with nonoxynol 9 latex condom or stopping before climax, cunnilingus (oral-vaginal) with rubber dam (a flat, latex barrier about 6 inches square), and urine contact (water sports).
- c. *Low-risk activities:* Mutual masturbation, exploring rectum or vagina wearing latex gloves, social (dry) kissing, body massage, hugging, body-to-body rubbing (frottage)

Knowledge of risks will empower the patient to make appropriate choices about sexual behavior.

3. Explain to the patient that absolutely safe behaviors include abstinence, solitary masturbation, fantasy, voyeurism, or a mutually monogamous relationship with a noninfected partner *to reinforce that all other sexual practices carry varying degrees of risk*.
4. As appropriate, discuss populations at high risk for sexually transmitted diseases. For example, if you suspect that the patient or the patient's partner is an I.V. drug abuser, dis-

cuss the high risk of HIV transmission for members of this population group. *Patients who are members of high-risk groups or whose partners are members of high-risk groups need to be especially vigilant about practicing safer sex to avoid disease transmission through repeated exposure.*

5. Provide the patient with basic information about how to effect change. Discuss the need to acknowledge that one's own behavior may create risk, the need to make a commitment to change, and the need to involve one's sexual partner or partners in the process. *Discussing how to effect change may empower the patient to modify his risk profile.*

6. Discuss the steps the patient needs to take to ensure safer sex. For example, before becoming aroused, the patient should discuss the boundaries of a sexual relationship with a potential partner. *Planning in advance for sexual activity will further empower the patient to decrease risky behavior.*

7. Support the patient's efforts to be assertive in setting sexual practice boundaries *to in-*

(continued)

† Numbers following outcomes refer to interventions.

Interventions and rationales (continued)

crease self-confidence and decrease the perception of powerlessness.

8. Instruct patient in proper use of condom and rubber dam *to reduce risk of infection*. Encourage the patient to practice using condom or dam before engaging in sexual activity. Tell the patient to:

- fully unroll the condom onto erect penis, pinch the end of the condom to allow reservoir for semen, and hold it at base of penis on withdrawal
- place the dam over entire vulva or rectum holding two edges of dam with hands
- use separate dams when practicing both oral-vaginal and oral-anal sex.
- keep condom or dam in a readily accessible place.
- always use a new condom or dam for each act of intercourse
- never use petroleum-based lubricants with condoms or rubber dams. *Petroleum-*

based lubricants greatly increase the risk of breaks or leaks in the protective materials.

9. Ask the patient how he feels about information you provide on safer sex practices and listen openly to the response. *Getting patient feedback will help you evaluate the learning process.*

10. Provide patient with names and telephone numbers of resource people or organizations, such as a community AIDS task force, *to provide continuity of care and follow-up after discharge.*

Documentation

- Patient's understanding of risks associated with various types of sexual activity
- Patient's statements of concern about risks created by current sexual practices
- Teaching provided
- Patient's response to teaching, including

statements about changes in sexual practices

- Evaluations for each expected outcome.

Care plan notes

Care plan notes

Definition

Failure to integrate program for treating illness into daily living

Assessment

- Medical history
- Physical examination
- Prescriptions for treatment, including medications, activity, diet, other
- Current medication schedule, including medications used at home (prescribed and over-the-counter)
- Activities of daily living and exercise pattern
- Nutrition pattern, including three-day diet history or one-day diet recall
- Weight
- Patient's and family's health-related goals
- Self-care abilities and resources, including presence of significant others
- Health beliefs, including perceived susceptibility to illness, perceived seriousness of illness, perceived effectiveness of treatment,

perceived barriers to managing regimen

- Other influences on health-related behavior, including age, sex, knowledge, social pressures

Defining characteristics

- Exacerbation (expected or unexpected) of illness
- Inappropriate choices with regard to meeting the goals of treatment or prevention program
- Patient expresses difficulty with integrating prescribed treatment regimen into life-style
- Patient reports failure to include treatment regimen in daily routine
- Patient reports failure to take action to reduce risk factors for illness

Associated medical diagnoses (selected)

Any illness has potential to be managed ineffectively by the patient. Common examples include acquired immunodeficiency syndrome, asthma, chronic fatigue syndrome, chronic obstructive pulmonary disease, chronic renal failure, coronary artery disease, diabetes mellitus, hypertension, multiple sclerosis, Parkinson's disease, rheumatoid arthritis, spinal cord injury

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient expresses personal beliefs about illness and its management. (1)
- Patient develops plan for integrating components of therapeutic regimen, such as medications, activity, and diet into pattern of daily living. (2,3,4)
- Patient selects daily activities to meet the goals of treatment or prevention program. (2,6,7)
- Patient expresses intent to reduce risk factors for progression of illness. (6,7)
- Patient uses available support services. (10)

Interventions and rationales

1. Discuss patient's personal beliefs about illness and review relevant information *to establish common understanding for development of plan of care.*
2. Educate patient about pathophysiology of illness and explain relationship between pathophysiology and therapeutic regimen. *A patient who knows the reasons for specific behaviors may be more willing to adjust life-style.*
3. Help patient and family clarify values associated with life-style *to enhance understanding*

of conflicts between life-style and demands of therapeutic regimen.

4. Work with patient and family to develop a daily routine for managing the therapeutic regimen. *Collaboration with patient and family makes it possible to combine scientific knowledge of the illness with life-style factors, such as culture, family dynamics, and finances.*
5. Correct patient's misconceptions about susceptibility to and seriousness of illness. *Misconceptions may undermine treatment.*
6. Assist patient and family in modifying factors (such as social pressures, lack of family support, or previous behavior patterns) that interfere with treatment management *to enhance the level of care.*
7. Provide verbal reminders to reinforce health-promoting behaviors. For example, remind a patient with heart disease to stop smoking. *Verbal cues may stimulate the patient to take action—if not immediately, then at a later point in time.*
8. Provide clearly written literature about treatment regimen *to reinforce patient's knowledge.*
9. Assist patient and family in selecting appro-

appropriate options for managing the therapeutic regimen to help them integrate complicated and disruptive interventions into their life-style.

10. Refer patient or family to support groups or self-help organizations *to empower patient and family to continue effective management of therapeutic regimen.*
11. Help patient and family plan for future course of illness. For example, they may need to make structural changes to their home to accommodate a wheelchair or hospital bed. *Planning ahead helps to ensure appropriate management of future contingencies.*

Documentation

- Patient's knowledge and beliefs about illness and therapeutic regimen
- Patient's explanation of values and life-style
- Information provided to clarify misconceptions
- Actions taken to modify patient's environment or behavior
- Written materials given to patient
- Referrals to support services
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

Definition

Limitation of physical movement

Assessment

- History of neuromuscular disorder or dysfunction
- Musculoskeletal status, including coordination, gait, muscle size and strength, muscle tone, range of motion, and functional mobility as follows:

- 0 = completely independent
- 1 = requires use of equipment or device
- 2 = requires help, supervision, or teaching from another person
- 3 = requires help from another person and equipment or device
- 4 = dependent; does not participate in activity

- Neurologic status, including level of consciousness, motor ability, sensory ability

Defining characteristics

- Decreased muscle strength, control, mass, endurance
- Impaired coordination
- Inability to purposefully move within the physical environment, including bed mobility, transfer, and ambulation
- Limited range of motion
- Reluctance to attempt movement

Associated medical diagnoses (selected)

Amyotrophic lateral sclerosis, cerebral palsy, cerebrovascular accident, multiple sclerosis, muscular dystrophy, myasthenia gravis, Parkinson's disease, poliomyelitis, rheumatoid arthritis, spinal cord injury (paraplegia, quadriplegia), tetanus

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient maintains muscle strength and joint range of motion. (1,2,3,4,5)
- Patient shows no evidence of complications, such as contractures, venous stasis, thrombus formation, or skin breakdown. (1,2,7,8)
- Patient achieves highest level of mobility (transfers independently, is wheelchair-independent, ambulates with such assistive devices as walker, cane, braces). (6,9,10,11,12,13,14)
- Patient or significant other carries out mobility regimen. (11,12)
- Patient or significant other makes plans to use resources to help maintain level of functioning, such as physical therapist, Stroke Program, American Heart Association, National Multiple Sclerosis Society, etc. (14)

Interventions and rationales

1. Perform range-of-motion exercises to joints, unless contraindicated, at least once every shift. Progress from passive to active, as tolerated. *This prevents joint contractures and muscular atrophy.*
2. Turn and position patient every 2 hours. Es-

tablish turning schedule for dependent patients; post at bedside and monitor frequency of turning. *This prevents skin breakdown by relieving pressure.*

3. Place joints in functional position, use trochanter roll along thigh, abduct thighs, use high-top sneakers, put small pillow under head, etc. *These measures maintain joints in functional position and prevent musculoskeletal deformities.*

4. Identify level of functioning using a functional mobility scale (see Assessment). Communicate patient's skill level to all staff to provide continuity and preserve identified level of independence.

5. Encourage independence in mobility by assisting patient in using trapeze and side rails, in using unaffected leg to move affected leg, and in performing such self-care activities as combing hair, feeding, dressing, etc. *This increases muscle tone and patient's self-esteem.*

6. Place items within reach of unaffected arm if one-sided weakness or paralysis is present to promote patient's independence.

7. Monitor and record daily any evidence of

immobility complications (contractures, venous stasis, thrombus, pneumonia, urinary tract infection). *Patients with history of neuromuscular disorders or dysfunctions may be more prone to develop complications.*

8. Carry out medical regimen to manage or prevent complications; for example, prophylactic heparin for venous thrombosis. *This promotes patient's health and well-being. ‡*

9. Provide progressive mobilization to limits of patient's condition (bed mobility to chair mobility to ambulation) to maintain muscle tone and prevent complications of immobility.

10. Refer to physical therapist for development of mobility regimen to help rehabilitate musculoskeletal deficits.

11. Encourage attendance at physical therapy sessions and support activities on unit by using same equipment and technique. Request written mobility plans and use as reference. *All members of health care team should reinforce learned skills in same manner.*

12. Instruct patient and family or significant other in range-of-motion exercises, transfers, skin inspection, mobility regimen to help

(continued)

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Interventions and rationales (continued)

prepare patient for discharge.

13. Demonstrate mobility regimen and note date. Have patient and family or significant other return mobility regimen demonstration and note date. *This ensures continuity of care and use of proper technique.*

14. Assist in identifying resources to carry out mobility regimen, such as Stroke Program, American Heart Association, National Multiple Sclerosis Society. *This helps provide comprehensive approach to rehabilitation.*

Documentation

- Patient's expression of concern about the loss of mobility, current status of functional abilities, and goals set for self
- Observations of the patient's mobility status, presence of complications, and response to mobility regimen

- Instruction and demonstration of skills in carrying out mobility regimen
- Patient's response to nursing interventions
- Evaluations for each expected outcome.

Care plan notes

Care plan notes

Definition

Limitation of physical movement

Assessment

- History of recent surgery, injury, or disorder causing pain or discomfort
- Medication history
- Musculoskeletal status, including coordination, gait, muscle size and strength, muscle tone, range of motion, and functional mobility as follows:
 - 0 = completely independent
 - 1 = requires use of equipment or device
 - 2 = requires help, supervision, or teaching from another person
 - 3 = requires help from another person and equipment or device
 - 4 = dependent; does not participate in activity
- Pain, including environmental and cultural influences, intensity, location, quality, temporal factors

- Psychosocial status, including coping mechanisms, family or significant others, life-style, personality, stressors (disease process, finances, job, marital discord)

Defining characteristics

- Clinical evidence or verbal complaint of pain on movement
- Decreased muscle strength, control, mass, or endurance
- Imposed restriction of movement, including mechanical; medical protocol
- Impaired coordination
- Inability to move purposefully within the physical environment, including bed mobility, transfer, and ambulation
- Limited range of motion
- Reluctance to attempt movement

Associated medical diagnoses (selected)

Ankylosing spondylitis, arthritis (all types), bursitis, dermatomyositis, dislocation, epicondylitis, fractures, gout, herniated disk, osteochondrosis, osteomyelitis, Paget's disease, peripheral neuritis, peripheral vascular disease, polymyositis, sickle-cell crisis, sprains, systemic lupus erythematosus, tendinitis, trauma

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient states relief from pain. (2,3,4,5)
- Patient displays increased mobility. (1,3,4,5,6,9)
- Patient shows no evidence of such complications as contractures, venous stasis, thrombus formation, or skin breakdown. (1,2,3,4,6,7,9)
- Patient attains highest degree of mobility possible within confines of disease. (3,4,5,6,7,9)
- Patient or significant other demonstrates mobility regimen. (7)
- Patient states feelings about limitations. (8,10)

Interventions and rationales

1. Observe patient's functional ability daily; document and report any changes using functional mobility scale (see Assessment). *Changes may indicate progressive decline or improvement in underlying disorder.*
2. Encourage patient to verbalize pain and discomfort. Observe for nonverbal cues of pain, including favoring a body part, grimacing, etc. *This aids assessment of location, quality, and intensity of pain.*

3. Perform prescribed treatment regimen for underlying condition producing pain or discomfort. Monitor progress and report favorable and adverse response to treatment *to assess effectiveness of treatment.* ‡
4. Provide supportive measures as indicated:
 - a. Administer pain medication and assess nonverbal cues, verbal reports, and vital signs *to monitor effectiveness.* ‡
 - b. Ensure patient comfort by padding extremities prone to skin breakdown (heels, elbows), ensuring correct measurement of crutches, using egg-crate mattress on bed, etc. *These measures prevent skin breakdown.*
 - c. Encourage patient's active movement by using assistive devices *to increase muscle tone and increase patient's feelings of self-esteem*; promote joint rest between activities.
 - d. Implement range-of-motion exercises every shift after pain medication, unless medically contraindicated; progress from passive to active, as tolerated. *This prevents joint contracture and muscle atrophy.*

- e. Reposition patient every 2 hours and provide meticulous skin care *to prevent skin breakdown.*
 - f. Promote progressive mobilization to maximum, within limits of patient's tolerance for pain (bed mobility to chair mobility to ambulation). *This maintains muscle tone and prevents complications of immobility.*
5. Discuss use of distraction and other non-pharmacologic pain-relief methods with patient. Instruct patient and family or significant other on the preferred method and monitor effectiveness. Encourage patient to choose an alternative if ineffective. Document response. *Many nonpharmacologic pain relief methods are available, from which patient can choose. Documentation helps ensure continuity of care.*
 6. Explain necessity of movement even during painful periods, unless contraindicated, to prevent greater pain, such as occurs in arthritic conditions, postsurgery, etc. Let patient know when to expect to move; provide pain-relief measures before moving patient. *Movement alleviates effects of immobility. Medication*

(continued)

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Interventions and rationales (continued)

alleviates pain and maintains patient's functional activity level.

7. Instruct patient and significant other in range-of-motion exercises, transfers, skin inspection, and mobility regimen. Have patient and significant other return mobility demonstration under supervision. *An informed patient and significant other will be better prepared to prevent complications of immobility.*

8. Encourage patient to discuss feelings and concerns about altered state of mobility *to reduce anxiety and promote compliance.*

9. Encourage adherence to other aspects of health care management *to control or minimize effects on mobility. This promotes health and well-being by alleviating pain and preventing complications.*

10. Refer to psychiatric liaison nurse, social service agency, support group, or other resources as appropriate *to provide patient with alternative approaches to care.*

Documentation

- Patient's expression of feelings and concerns about immobility, impact on life-style, and willingness to participate in care
- Observations of patient's impaired mobility, pain, and response to treatment
- Interventions to provide supportive care
- Instructions to patient and significant other, their understanding of instructions, and demonstrated skill in carrying out the prescribed mobility and pain-relief program
- Patient's response to nursing interventions
- Evaluations for each expected outcome.

Care plan notes

Care plan notes

Definition

Limitation of physical movement

Assessment

- History of neurologic, sensory, or psychological disorder with impaired movement
- Musculoskeletal status, including coordination, gait, muscle size and strength, muscle tone, range of motion, and functional mobility as follows:
 - 0 = completely independent
 - 1 = requires use of equipment or device
 - 2 = requires help, supervision, or teaching from another person
 - 3 = requires help from another person and equipment or device
 - 4 = dependent; does not participate in activity
- Neurologic status, including cognition, communication skills, insight and judgment, level of consciousness, memory, motor ability, orientation, sensory ability

- Psychosocial status, including coping mechanisms, family or significant others, life-style, personality, stressors (disease process, finances, job, marital discord)

Defining characteristics

- Clinical evidence of impaired memory or intellectual capacity
- Decreased muscle strength, control, mass
- Impaired coordination
- Inability to move purposefully within the physical environment, including bed mobility, transfer, ambulation
- Limited range of motion
- Reluctance to attempt movement
- Restriction of movement, including mechanical, imposed by medical protocol

Associated medical diagnoses (selected)

Alcoholism, Alzheimer's disease, bipolar disease (manic or depressive phase), blindness, brain tumor, central nervous system infections, cerebrovascular accident, head injury, Huntington's disease, Laennec's cirrhosis, Ménière's disease, myxedema, pellagra, Reye's syndrome, vitamin B₁ deficiency

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient maintains functional mobility. (1,3,5,6,7,8)
- Complications are avoided or minimized. (1,2,3,5,6,7,9)
- Patient states feelings about impairment. (4)
- Family or significant other communicates understanding of mobility regimen. (8)
- Family or significant other demonstrates skill in carrying out mobility regimen. (8)
- Family or significant other obtains support necessary to continue care. (10)

Interventions and rationales

1. Observe patient's functional ability daily; document and report any changes using functional mobility scale (see Assessment). *Changes may indicate progressive decline or improvement in underlying disorder.*
2. Determine patient's degree of perceptual or cognitive impairment and ability to follow directions *to determine presence of deficits. Modify interventions accordingly.*
3. Perform prescribed treatment regimen for the underlying condition producing pain or discomfort. Monitor progress, reporting favorable

and adverse response to treatment, *to assess effectiveness of treatment.* ‡

4. Allow patient and family or significant other to ventilate frustration and other negative feelings regarding difficulty in performing mobility tasks. *Expressing feelings helps patient and family or significant other cope with impaired mobility.*
5. Ask patient to perform one task at a time; offer encouragement and provide simple, direct instructions ("walk to the bathroom") to avoid confusion. *Limiting new skills to small, critical units enhances learning.*
6. Provide patient with ample time to perform each new mobility-related task. *Patient may need extensive supervision and repetition to master new tasks.*
7. Provide supportive measures as indicated:
 - a. Perform range-of-motion exercises to joints (unless medically contraindicated) every shift; progress from passive to active, as tolerated, and monitor progress. *This prevents joint contracture and muscle atrophy.*
 - b. Turn and position patient every 2 hours; establish a turning schedule for depen-

dent patients. Post at bedside and monitor effectiveness. *Regular turning and positioning prevents skin breakdown.*

- c. Place joints in functional position (for example, trochanter roll along thigh) on an alternating schedule. *This prevents musculoskeletal deformities.*
 - d. Encourage patient's active movement by use of trapeze and side rails, using unaffected leg to move affected leg, and performance of self-care activities. Provide frequent reinforcement and demonstrations. *This increases muscle tone and feelings of self-esteem and reinforces learning.*
 - e. Walk patient with one or two assistants on regular schedule, if possible. *This preserves muscle tone, has positive psychological effect on patient and family, and prevents complications of immobility.*
8. Teach patient (if capable) and family or significant other how to perform range-of-motion exercises, transfers, skin inspection and mobility regimen; provide time for return demonstrations with supervision. *Informed patient*

(continued)

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Interventions and rationales (continued)

and significant other will be better prepared to prevent complications of immobility.

9. Encourage adherence to other aspects of health care management to control or minimize effects on mobility. *This promotes health and well-being by alleviating pain and preventing complications.*

10. Refer to psychiatric liaison nurse, social service agency, support group, or other resources as appropriate *to provide patient with alternative approaches to care.*

Documentation

- Observations of patient's impaired mobility, perceptual or cognitive status, and response to treatment
- Interventions to provide supportive care
- Instructions to patient and family or significant other, their understanding of instructions, and demonstrated skill in carrying out the prescribed mobility program

Care plan notes

- Patient's response to nursing interventions
- Patient's and family's or significant other's expressions of feelings and concern about immobility, impact on life-style, and capacity for participating in care
- Evaluations for each expected outcome.

Care plan notes

Definition

Lack of awareness of a body part

Assessment

- History of neurologic impairment
- Age
- Neurologic status, including awareness of body parts, cognition, level of consciousness, mental status, memory, sensory function, orientation, position sense, visual acuity, visual fields, ability to communicate (verbally and nonverbally), bowel and bladder control
- Musculoskeletal status, including coordination, muscle size and strength, muscle tone, range of motion, and functional mobility as follows:

- 0 = completely independent
- 1 = requires use of equipment or device
- 2 = requires help, supervision, or teaching from another person
- 3 = requires help from another person and equipment or device

4 = dependent; does not participate in activity

- Integumentary status, including color, texture, turgor, temperature, elasticity, sensation, moisture, hygiene, lesions
- Psychosocial status, including coping mechanisms, family or significant others, lifestyle, understanding of physical condition
- Self-care abilities, including preparation of equipment and supplies, technical or mechanical skills, use of assistive devices

Defining characteristics

- Denial of parts of the body affected by neurologic illness or trauma, either by refusing to acknowledge the paralysis, by neglecting the involved side, or by attributing ownership of a paralyzed limb to someone else
- Consistent inattention to stimuli on affected side
- Inadequate self-care
- Lack of awareness of body parts

Associated medical diagnoses (selected)

Bell's palsy, body image agnosia, cerebrovascular accident, head injury, hemianopsia, neoplastic brain disease

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient avoids injury to affected body part. (1,7,9,10,11,12)
- Patient avoids skin breakdown. (1,5,8)
- Patient avoids contractures. (1,4,9,10)
- Patient recognizes neglected body part. (2,3,4,6)
- Patient and family or significant other demonstrate measures to protect affected body part. (4,10)
- Patient and family or significant other demonstrate exercises for affected body part. (6)
- Patient and family or significant other express feelings about altered state of health and neurologic deficits. (13)
- Patient and family or significant other identify community resources and support groups to help cope with the effects of illness. (14)

Interventions and rationales

1. Place sling on affected arm *to prevent dangling or injury*. Support affected leg and foot while patient is in bed, place foot strap on wheelchair, and perform other measures as appropriate *to keep limbs in functional position and avoid contractures*. Use draw sheet to

move patient up in bed *to avoid skin abrasions*.

2. Touch and rub affected limbs. Describe them in conversation with patient *to remind patient of neglected body parts*.

3. Direct patient to perform activities which require use of affected limbs. *A patient who experiences usefulness of paretic or paralyzed limb will more easily integrate affected limb into his body image*.

4. Encourage patient to check position of affected body parts with each repositioning or transfer *to reestablish awareness of body part*.

5. Establish and follow a regular turning schedule *to maintain skin integrity*.

6. Request consultations with occupational and physical therapists regarding adaptive equipment, exercise program, and other recommendations *to increase awareness of affected limbs*. ‡

7. Use safety belts or protective devices according to hospital policy *Safety devices remind patient of limitations and help prevent falls*.

8. Remove splints and other devices at least every two hours. Inspect skin for pressure

areas. Reapply splint. *Proper use of splints and other devices prevents deformities and maintains skin integrity*.

9. Perform range-of-motion exercises to the affected side at least once every shift, unless medically contraindicated, *to maintain joint flexibility and prevent contractures*.

10. Instruct family and nursing personnel to observe position of affected body parts frequently. Remove food or drainage from face if unnoticed by patient. Place arm or leg in proper position as often as necessary *to prevent injury*.

11. Arrange environment for maximum functioning; for example, place water, TV controls, and call light within reach. *These measures enhance orientation and encourage independence*.

12. Assist activities of daily living or provide supervision, as appropriate, *to protect the patient's affected side*.

13. Encourage patient and family members or significant others to express feelings regarding the patient's condition and level of functioning *to release tension and enhance coping*.

(continued)

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Interventions and rationales (continued)

14. Refer patient and family or significant other to appropriate support groups and other community resources *to assist patient and family in adjusting to altered state of health.*

Documentation

- Patient's expressions of feelings about neglected side of body
- Safety measures taken to prevent injury
- Patient's ability to perform activities of daily living and nursing measures taken to overcome deficits
- Observations of patient's and family's coping skills
- Patient's response to nursing interventions, including verbal expressions or behavior that indicate increased awareness of affected limb
- Evaluations for each expected outcome.

Care plan notes

Interventions and rationales (continued)

14. Refer patient and family or significant other to appropriate support groups and other community resources *to assist patient and family in adjusting to altered state of health.*

Documentation

- Patient's expressions of feelings about neglected side of body
- Safety measures taken to prevent injury
- Patient's ability to perform activities of daily living and nursing measures taken to overcome deficits
- Observations of patient's and family's coping skills
- Patient's response to nursing interventions, including verbal expressions or behavior that indicate increased awareness of affected limb
- Evaluations for each expected outcome.

Care plan notes

Care plan notes

Definition

Inability to practice prescribed health-related behaviors resulting from lack of resources

Assessment

- Age
- Resources, including income level, public assistance, eligibility for Medicare or Medicaid, other financial resources, additional resources available to family, accessibility of community resources
- Presence or absence of health insurance
- Employment status
- Educational background
- Fluency in English language
- Location of residence
- Cost of treatment, equipment, and services

Defining characteristics

- Evidence of complications
- Evidence of symptom exacerbation
- Failure to adhere to treatment regimen, as evidenced by direct observation of patient's behavior or statements by the patient, family, or significant other
- Failure to keep appointments
- Failure to progress
- Income below poverty level
- Ineligibility for Medicare or Medicaid
- Lack of insurance coverage
- Unemployment

Associated medical diagnoses (selected)

This nursing diagnosis can occur in association with any medical diagnosis and depends upon the patient's access to and knowledge of resources

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient identifies barriers to compliance. (1,2,3)
- Patient identifies community resources and means to obtain health care and social services. (3,4,5,6,7)
- Patient takes steps to utilize community resources. (6,7,8)
- Patient complies with health care regimen. (1,2,3,4,6,7,8,9)

Interventions and rationales

1. Establish a trusting nurse-patient relationship *to facilitate open communication.*
2. Discuss patient's reasons for noncompliance *to determine appropriate interventions.*
3. Obtain and use language interpreter if needed. *Lack of fluency in English language may be one barrier in patient's attempts to secure community resources.*
4. Assess patient's health care needs, socioeconomic status, insurance status, and available family resources *to determine if patient meets eligibility criteria for receiving aid from government or community sources.*
5. Evaluate limitations of community re-

sources, such as difficulty obtaining initial appointment or lengthy waits before appointments *to identify potential barriers to using available health care or social services.*

6. Provide clearly written information (translated into the patient's native language if necessary) on community resources from which the patient is qualified to receive services. *Patient may not know about available resources or may have difficulty understanding complex admission criteria.*

7. Refer patient to appropriate agency. Set up initial appointment and provide names of health care professionals to be seen *to begin the process of tapping into available resources and to demonstrate to the patient how to go about this process.*

8. Provide the patient with information on assertiveness training *to empower the patient to deal with the health care bureaucracy on his own.*

9. Advocate for better health care at the community, state, or national level. *Ultimately, addressing inequities in health care may require broad health-policy reform.*

Documentation

- Patient's statements explaining reasons for noncompliant behavior
- Community and family resources available to patient
- Evidence of patient's daily progress in overcoming barriers to obtaining health care
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

Definition

Unwillingness to practice prescribed health-related behaviors

Assessment

- Age
- Health beliefs
- Patient's perceptions of health problem, treatment regimen, and importance of complying with treatment regimen
- Patient's ability to learn and perform prescribed treatment (activity, diet, medications)
- Financial resources
- Cultural and ethnic influences
- Religious influences
- Educational and language background

Defining characteristics

- Challenged beliefs and value systems
- Evidence of complications
- Evidence of symptom exacerbation
- Failure of objective tests
- Failure to adhere to treatment regimen, indicated either through direct observation of behavior or statements by the patient, family, or significant other
- Failure to keep appointments
- Failure to progress
- Inability to set or attain mutual goals

Associated medical diagnoses (selected)

This nursing diagnosis can occur in association with any medical diagnosis and depends upon the patient's value system.

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient identifies factors that influence non-compliance. (1,2,3,4)
- Patient demonstrates a level of compliance that does not interfere with physiologic safety. (5,6,7)
- Patient contracts with nurse to perform _____ (specify behavior and frequency). (8)
- Patient uses support systems to modify non-compliant behavior. (6,7,9,10)

Interventions and rationales

1. Listen to patient's reasons for noncompliance. *Active listening may reveal concerns not clearly stated in words and helps individualize teaching process.*
2. Approach patient in a nonjudgmental manner. *This demonstrates unconditional positive regard for the patient.*
3. Identify specific areas of patient's noncompliant behavior to help develop appropriate interventions.
4. Attempt to identify influencing factors associated with noncompliant behaviors, such as lack of understanding, unrealistic expectations, or cultural differences. *Reasons for noncompli-*

ance may range widely and include lack of knowledge, forgetting, feeling better or worse, and getting contradictory advice from family, friends, and health care providers.

5. Emphasize the positive aspects of compliance; *it can reduce risk factors, prevent complications, and help manage certain chronic diseases.*
6. Assist patient with values clarification process *because values have both intellectual and emotional components and form a basis for patient's behavior.*
7. Acknowledge patient's right to choose against carrying out the prescribed regimen. *Patient's autonomy must be respected; control over patient's action is legitimate only if needed to prevent harm to the patient, to others, or to yourself.*
8. Contract with patient for behaviors that are not threatening. *This involves both patient and caregiver in formal commitment and gives patient sense of personal control.*
9. Use support systems to enforce or reinforce negotiated behaviors. *Support from patient's family helps foster compliance.*
10. Give positive reinforcement for compliant

behavior to encourage the patient to continue such behavior.

Documentation

- Patient's statements that indicate noncompliant behavior
- Direct observation of noncompliant behavior
- Statements by patient that provide insight into causes of noncompliant behavior
- Terms agreed upon by the patient in performing negotiated behaviors
- Patient's daily progress in complying with treatment regimen
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

Nutrition alteration, high risk for: More than body requirements

related to excessive intake

94

Definition

Accentuated risk of change in normal eating pattern that results in increased body weight

Assessment

- Nutritional history, including financial resources, height and weight, hereditary influences, history of obesity, meal preparation, sociocultural influences, usual dietary pattern, weight fluctuations over past year
- Eating patterns, including internal and external cues that trigger desire to eat, rate of food consumption, stated food preferences
- Psychosocial status, including behavior, mood, stressors (finances, job, marital discord), coping mechanisms, sources of support (family, friends, others), life-style, knowledge level, hobbies, interests
- Activity levels
- Body image, including perception of observer and self-perception

- Additional circumstances which may lead to excessive intake

Risk factors

- History of obesity
- Sedentary life-style
- Obesity in one or both parents
- Reduced motor ability
- Immobility
- Excessive preoccupation with food
- Cognitive or emotional difficulties, such as perfectionism, dichotomous thinking, negative self-talk, isolation from support person or group
- Dysfunctional eating patterns, such as concentrating food intake at end of day, eating in response to internal cues other than hunger (guilt, anger, depression), pairing food with other activities, hiding food away for later use, eating in response to external cues (time of day, social situations, television advertisements)

- Use of food to stave off boredom or relieve stress or as a reward or comfort measure

Associated medical diagnoses (selected)

Anxiety, depression, diabetes mellitus

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient expresses need to maintain or stabilize weight within 5 to 10 pounds of target weight. (1,2,3,8)
- Patient plans to monitor weight and sustain target weight. (1,2,3,4,6,8,10)
- Patient expresses feelings regarding dietary regimen and current weight. (5)
- Patient identifies internal and external cues which lead to increased food consumption. (5,8)
- Patient plans menus appropriate for prescribed diet. (7)
- Patient adheres to prescribed diet. (7,8,9,10)
- Patient participates in selected exercise program every week (specify). (11)

Interventions and rationales

1. Weigh patient weekly or as prescribed to monitor effectiveness of diet.
2. Work with patient to establish realistic target weight. Instruct patient how to record weight. *Involvement in nursing care plan improves compliance.*
3. Instruct patient to keep food diary. *This helps patient confront actual intake, break*

through denial, and achieve a more objective view of eating habits.

4. Monitor fluid intake and output and assess for edema. *Fluid retention may increase body weight.*
5. Encourage expression of feelings about dietary restrictions to assess patient's perception of problem. Help the patient identify emotions associated with food and situations which trigger eating episodes. *Permanent weight maintenance requires an understanding of risk factors that contribute to weight gain.*
6. Determine the patient's food likes and dislikes to evaluate eating habits and include preferred foods in the diet.
7. Encourage consumption of foods low in calories and fat, and high in complex carbohydrates and fiber. Have the patient meet with the dietitian to discuss meal planning. *These steps will help the patient plan nutritious and well-balanced meals.*
8. Refer the patient to the appropriate resource for behavior modification and cognitive therapy to prevent relapse into high-risk eating behaviors.
9. Give the patient emotional support and pos-

itive feedback for adhering to the prescribed diet. *This will foster compliance and help ensure adherence to regimen.*

10. Recommend that the patient explore group diet therapies, such as Weight Watchers or Overeaters Anonymous to provide additional sources of information and encouragement.
11. Discuss the importance of incorporating exercise into life-style. Help the patient select a varied program of activities (swimming, walking, aerobics, biking) appropriate for age and physical condition. *Besides burning calories, exercise offers an alternative to eating to alleviate stress and fosters a sense of accomplishment.*

Documentation

- Patient's expression of feelings about weight, eating, and dietary regimen
- Patient's weight
- Ability of patient to maintain target weight
- Foods consumed by patient
- Behaviors that facilitate or impede weight maintenance
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

Nutrition alteration: Less than body requirements

related to inability to digest or absorb nutrients resulting from biological factors

95a

Definition

Change in normal eating pattern that results in changed body weight

Assessment

- GI assessment, including antibiotic therapy, auscultation of bowel sounds, change in bowel habits, stool characteristics (color, amount, size, consistency), history of GI disorder or surgery, inspection of abdomen, pain or discomfort, usual bowel pattern, palpation for masses and tenderness, and percussion for tympany, dullness, nausea and vomiting
- Nutritional status, including change in type of food tolerated, financial resources, height and weight, meal preparation, serum albumin level, sociocultural influences, usual dietary pattern, weight fluctuations over past 10 years
- Change in intrapersonal or interpersonal factors, including internal or external cues that trigger desire to eat, rate of food consumption, and stated food preference

- Psychosocial status
- Activity level
- Coping behaviors
- Body image, including perception of observer and self-perception

Defining characteristics

- Abdominal pain with or without pathologic condition
- Body weight 20% or more under ideal weight for height and frame
- Diarrhea, steatorrhea
- Halitosis, coated tongue
- Hyperactive bowel sounds
- Loss of body weight with adequate food intake
- Pale conjunctiva and mucous membranes
- Perceived inability to digest food
- Poor muscle tone
- Poor skin turgor
- Pressure sores
- Reported inadequate food intake; less than

recommended daily allowances

- Sore, inflamed buccal cavity
- Weakness of muscles required for chewing or swallowing

Associated medical diagnoses (selected)

Acute gastritis, bleeding esophageal varices, cholecystitis, cirrhosis, Crohn's disease, diverticulitis, dumping syndrome, hepatitis, intestinal obstruction, malabsorption syndrome, pancreatitis, paralytic ileus, peptic ulcer, peritonitis, tumors of GI tract, ulcerative colitis

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient shows no further evidence of weight loss. (1,2,3,4,5,6,7,8)
- Patient tolerates oral, tube, or I.V. feedings without adverse effects. (9,10,11)
- Patient takes in _____ calories daily. (1,2,3,4,5,6,7,8,9)
- Patient gains _____ lb weekly. (1,2,3,4,5,6,7,8)
- Patient states understanding of tube feeding, total parenteral nutrition, preoperative instruction. (14)
- Patient and family or significant other communicate understanding of special dietary needs. (12,13,15,16)
- Patient and family or significant other demonstrate ability to plan diet after discharge. (14,15,16)

Interventions and rationales

1. Obtain and record patient's weight at the same time every day *to obtain the most accurate readings.*
2. Monitor fluid intake and output *because body weight may increase as a result of fluid retention.*

3. Maintain parenteral fluids, as ordered, *to provide patient with needed fluids and electrolytes.* ‡
4. Provide diet prescribed for patient's specific condition, *to improve patient's nutritional status and increase weight.* ‡
5. Determine food preferences and provide them within limitations of patient's prescribed diet. *This enhances compliance with diet regimen.*
6. Monitor electrolytes and report abnormal values. *Poor nutritional status may cause electrolyte imbalances.* ‡
7. If patient vomits, record amount, color, and consistency. Keep a record of all stools. *Vomitus and stool characteristics indicate status of nutrient absorption.*
8. Refer to dietician or nutritional support team for dietary management (possible regimens include yogurt feedings or low-bulk diet.) *Dietician or nutritional support team can help patient and health team individualize diet within prescribed restrictions.*
9. If patient is receiving tube feeding:
 - a. Add food coloring if patient has an altered state of consciousness or dimin-

- ished gag reflex *to help detect aspiration.*
 - b. If possible, use continuous infusion pump *to avoid diarrhea.*
 - c. Begin regimen with small amount and diluted concentration *to decrease diarrhea and improve absorption.* Increase volume and concentration as tolerated.
 - d. Keep head of bed elevated during feeding *to reduce risk of aspiration.*
 - e. Check feeding tube placement each shift *to verify placement in GI tract rather than in lungs.*
10. If patient receives total parenteral nutrition:
 - a. Ensure delivery as prescribed. *Electrolytes, amino acids, and other nutrients must be tailored to patient's needs.*
 - b. Monitor blood glucose, urine specific gravity, and urine glucose and ketones at least once a shift. *Since glucose comprises the major component of hyperalimentation, patient may become hyperglycemic if not carefully monitored.* ‡
 11. Monitor bowel sounds once a shift. *Normal active bowel sounds may indicate readiness*

(continued)

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Nutrition alteration: Less than body requirements

related to inability to digest or absorb
nutrients resulting from biological factors

95b

Interventions and rationales (continued)

for enteral feedings; hyperactive sounds may indicate poor absorption and may be accompanied by diarrhea.

12. Reinforce medical regimen by explaining to patient and family or significant other the reasons for present regimen. *Collaborative practice enhances patient's overall care.*

13. Teach principles of good nutrition for the specific condition. *This encourages patient and significant others to participate in patient's care.*

14. Provide or assist with oral hygiene *to help keep patient comfortable.*

15. Provide preoperative teaching, if needed, *to reduce patient's fear and anxiety and promote understanding.*

16. Involve family and significant other in meal planning *to encourage them to help patient comply with diet regimen after discharge.*

Documentation

- Daily weights
- Mouth care
- Maintenance of nasogastric tube
- Intake and output
- Patient's ability to eat
- Incidence of vomiting or diarrhea
- Presence of other complications
- Patient's statements of understanding of dietary education
- Evaluations for each expected outcome.

Care plan notes

Care plan notes

Nutrition alteration: Less than body requirements

related to inability to ingest foods

96

Definition

Change in normal eating pattern that results in changed body weight

Assessment

- GI assessment, including auscultation of bowel sounds; change in bowel habits; characteristics of stool (color, amount, size, consistency); history of GI disorder or surgery; inspection of abdomen; pain or discomfort; palpation for masses, tenderness; percussion for tympany, dullness; nausea, vomiting; usual bowel pattern
- Nutritional status, including financial resources, height, meal preparation, serum albumin level, sociocultural influences, usual dietary pattern, weight, weight fluctuations over past 10 years
- Intrapersonal and interpersonal factors, including internal and external cues that trigger desire to eat, rate of food consumption, stated food preference

- Psychosocial status
- Activity level
- Coping behaviors
- Body image, including perception of observer, self-perception

Defining characteristics

- Abdominal pain with or without pathologic condition
- Body weight 20% or more under ideal weight for height and frame
- Diarrhea or steatorrhea
- Hyperactive bowel sounds
- Loss of body weight with adequate food intake
- Poor muscle tone
- Reported inadequate food intake: less than recommended daily allowances
- Sore, inflamed buccal cavity
- Weakness of muscles required for swallowing or mastication

Associated medical diagnoses (selected)

Acute gastritis, Alzheimer's disease, bleeding esophageal varices, cerebrovascular accident, cholecystitis, cirrhosis, Crohn's disease, diverticulitis, dumping syndrome, dysphagia, head injury, hepatitis, intestinal obstruction, malabsorption syndrome, pancreatitis, paralytic ileus, peptic ulcer, peritonitis, tumors of GI tract, ulcerative colitis

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient shows no further evidence of weight loss. (1)
- Patient tolerates _____ ml of nasogastric or gastrostomy tube feedings. (2,3,6)
- Patient avoids aspiration. (8)
- Patient avoids episodes of diarrhea. (7)
- Patient gains _____ lb weekly. (1)
- Patient avoids skin breakdown or infection around tube site. (4,5)
- Patient and family or significant other communicate understanding of special dietary needs. (9)
- Patient and family or significant other demonstrate correct tube feeding procedures. (9)

Interventions and rationales

1. Obtain and record patient's weight at the same time every day *to obtain the most accurate readings.*
2. Monitor fluid intake and output *because body weight may increase as a result of fluid retention.*
3. Administer prescribed amount of tube feeding *to provide patient with needed nutrition.* ‡
 - a. Begin regimen with small amount and di-

luted concentration *to decrease diarrhea and improve absorption.* Increase volume and concentration as tolerated.

- b. Elevate head of bed during infusion *to reduce risk of aspiration.*
 - c. Check feeding tube placement at least once every shift *to verify placement in GI tract rather than in lungs.*
 - d. Give water and juices, as needed, *to maintain adequate hydration.*
 - e. If possible, use continuous infusion pump *to avoid diarrhea.*
 - f. Put food coloring in tube feeding *to monitor for aspiration.*
4. Provide nares care every 4 hours *to prevent ulceration and skin breakdown.* Tape nasogastric tube *to prevent visual obstruction.* Use hypoallergenic tape *to minimize skin reactions.*
 5. Change gastrostomy dressing daily or according to institutional protocol.
 6. Ensure proper temperature of feeding (room temperature); change feeding tube bags and tubing according to institutional protocols.
 7. Assess and record bowel sounds once a shift *to monitor for an increase or decrease.*
 8. Auscultate and record breath sounds every

4 hours *to monitor for aspiration.* Report wheezes, rhonchi, crackles, or decreased breath sounds. If aspiration is suspected, stop tube feeding. Keep suction apparatus at bedside and suction as needed. Turn client on side *to avoid further aspiration.*

9. Instruct patient and family or significant other in tube feeding procedures. Supervise return demonstrations until competence is achieved. *This encourages patient and significant others to participate in patient's care.*

Documentation

- Daily weights
- Intake and output
- Tolerance of tube feeding
- Incidents of vomiting, aspiration, diarrhea
- Bowel sounds
- Breath sounds
- Response to instructions
- Demonstration of feeding procedures
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Nutrition alteration: Less than body requirements

related to psychological factors

97

Definition

Change in normal eating pattern that results in changed body weight

Assessment

- Nutritional history, including financial resources, height and weight, hereditary influences, meal preparation, sociocultural influences, usual dietary pattern, weight fluctuations over past 10 years
- Change in intrapersonal or interpersonal factors, including internal and external cues that trigger desire to eat, rate of food consumption, stated food preference
- Activity level
- Coping behaviors
- Body image, including perception of observer and self-perception

Defining characteristics

- Abdominal pain with or without pathologic condition
- Aversion to eating
- Body weight 20% or more under ideal weight for height and frame
- Diarrhea
- Lack of interest in food
- Pale conjunctiva and mucous membranes
- Perceived inability to ingest food
- Poor muscle tone
- Reported inadequate food intake; less than recommended daily allowances

Associated medical diagnoses (selected)

Anorexia nervosa, bipolar disease (manic or depressive phase), bulimia, depression

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient consumes a minimum of _____ calories daily. (2,3,4,5,6,7,8,9,10)
- Patient gains _____ lb weekly. (2,3,4,5,6,7,8,9,10,11,12)
- Patient eats independently, without being prodded. (7,8,9,10)
- Patient identifies emotional and psychological factors that interfere with eating. (1)
- Patient develops a plan to monitor and maintain target weight at discharge. (13,14)
- Patient plans to use mental health resources to help resolve psychological problems. (14)

Interventions and rationales

1. Provide opportunities for patient to discuss reasons for not eating *to help assess causes of eating disorder.*
2. Observe and record patient's intake (both liquid and solid) *to assess which nutrients are consumed and which supplements are needed.*
3. Determine patient's food preferences and attempt to obtain these foods. Offer foods that appeal to olfactory, visual, and tactile senses *to enhance patient's appetite.*
4. Offer high-protein, high-calorie supplements, such as milk shakes, custard, or ice cream. *Such foods prevent body protein breakdown and provide caloric energy. ‡*
5. Serve foods that require little cutting or chewing *to help prevent malingering at meals.*
6. Provide a pleasant environment at mealtime *to enhance patient's appetite.*
7. Keep snacks at bedside *to give patient some control over eating time.*
8. With some patients, begin with nutritious liquids and gradually introduce solids. *A severely malnourished patient may not be able to chew solid foods immediately.*
9. Avoid asking whether patient is hungry or wants to eat. Be positive in offering food. *A positive, undemanding attitude avoids confrontation with patient.*
10. Whenever possible, sit with patient for predetermined length of time during meal. *This inhibits patient from dawdling during meal, or from hiding or hoarding food.*
11. Monitor and record elimination patterns. *Patient may be taking laxatives or diuretics to keep weight low in spite of eating.*
12. Weigh patient at the same time every day.

Reinforce weight gain with privileges or rewards. *This yields accurate data and gives patient some control over food eaten and privileges or rewards gained.*

13. Set target weight and have patient record daily weight, *to involve patient in treatment.*

14. Refer patient and significant others to appropriate mental health professional. *Most eating disorders are psychological. Patient and significant others must be followed and treated to prevent recurrence. ‡*

Documentation

- Patient's expressed attitudes toward food and eating at the present time
- Patient's expressed feelings about weight, body image, emotional status
- Patient's daily intake (liquid and solid) and output (urine, stool, vomitus)
- Daily weights; progression of weight gain
- Interventions to feed patient adequately
- Emotional support provided
- Patient's response to nursing interventions
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Nutrition alteration: More than body requirements

related to excessive intake

98

Definition

Change in normal eating pattern that results in changed body weight

Assessment

- Nutritional history, including financial resources, height and weight, hereditary influences, history of obesity, meal preparation, sociocultural influences, usual dietary pattern, weight fluctuations over past 10 years
- Change in intrapersonal or interpersonal factors, including internal and external cues that trigger desire to eat, motivation to lose weight, rate of food consumption, stated food preference
- Psychosocial status
- Activity level
- Coping patterns
- Body image, including perception of observer and self-perception

Defining characteristics

- Body weight 10% or more over ideal weight for height and frame
- Clinical obesity
- Dysfunctional eating patterns, such as concentrating food intake at end of day, eating in response to internal cue other than hunger (anxiety, for example), eating in response to such social cues as time of day and social situation, pairing food with other activities
- Observed use of food as a reward or comfort measure
- Reported or observed obesity in one or both parents
- Triceps skin fold greater than 15 mm in men and 25 mm in women

Associated medical diagnoses (selected)

Anxiety, depression, diabetes mellitus, Pickwickian syndrome

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient voices feelings about present weight. (1)
- Patient identifies internal and external cues that increase food consumption. (2,3,4)
- Patient states need to lose weight. (4,6)
- Patient sets a weight-loss goal of _____ lb weekly. (4,6,8)
- Patient plans menus appropriate to prescribed diet. (3,5)
- Patient adheres to prescribed diet. (3,5,7)
- Patient loses a minimum of _____ lb weekly. (4,7,8)
- Patient sets target weight before discharge. (4,9)
- Patient states plan to monitor and maintain target weight. (4,10)
- Patient participates in selected exercise program _____ times weekly. (11)

Interventions and rationales

1. Help patient identify the problem, feelings associated with eating, and circumstances in which patient turns to food. *Permanent weight loss starts with examination of factors contributing to weight gain.*

2. Discuss patient's normal food preferences *to evaluate eating habits and include preferred foods in patient's diet.*

3. Have dietician discuss meal planning with patient during hospitalization *to help patient plan nutritious, satisfying meals.*

4. If resource is available, refer patient to a mental health professional for behavior modification *to help patient change poor eating habits and ensure permanent weight loss.* ‡

5. Teach patient about low-calorie, nutritious foods. *This encourages patient to eat foods that provide energy without causing weight gain.*

6. Help patient set realistic goals for losing weight. *This aids positive reinforcement and reduces frustration.*

7. Give patient emotional support and positive feedback for adhering to prescribed dietary regimen *to promote compliance.* Encourage nondietary rewards, such as purchase of a new accessory or book, *to promote continuation of dietary plan and help patient avoid using food as a reward.*

8. Weigh patient weekly or as prescribed *to monitor effectiveness of diet plan.*

9. Set target weight with patient and have patient record weight. *This involves patient in plan and provides positive reinforcement.*

10. Explore feasibility of having patient participate after discharge in Weight Watchers, Overeaters Anonymous, or other group or individual diet therapies. *Such resources provide reinforcement and information.*

11. Help patient select an exercise program (walking, jogging, aerobics, swimming) appropriate to age and physical condition. *Besides aiding weight loss, activities offer an alternative to eating to alleviate stress.*

Documentation

- Patient's expressions of feelings about weight, eating, food, dieting
- Goals set by patient
- Record of weight
- Foods consumed by patient
- Behaviors that facilitate or impede weight reduction
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Definition

Altered mouth integrity

Assessment

- History of pathologic conditions known to cause dehydration, such as diabetes
- Medications such as diuretics and antihistamines
- Vital signs
- Fluid and electrolyte status, including blood urea nitrogen, creatinine, intake and output, mucous membranes, serum electrolytes, skin turgor, urine specific gravity
- Oral status, including inspection of oral cavity (gums and tongue), pain or discomfort, salivation
- Nutritional status, including current weight, change from normal weight, and dietary pattern

- Psychosocial status, including change in financial status, coping skills, habits (smoking, alcohol intake), patient's perception of health problem, recent traumatic event

Defining characteristics

- Clinical evidence of dehydration
- Coated tongue
- Decreased or absent salivation
- Dry mouth
- Halitosis
- Oral lesions or ulcers
- Oral pain or discomfort
- Oral plaque
- Stomatitis
- Thirst

Associated medical diagnoses (selected)

Alcoholism, anorexia nervosa, depression, diabetes insipidus, diabetes mellitus (uncontrolled), drug-induced stomatitis, fever, GI dysfunction involving vomiting or diarrhea, heat exhaustion, heat stroke, hemorrhage, hypovolemic shock, NPO status, oxygen therapy, postoperative status, radiation therapy

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient maintains fluid balance (intake equals output). (2)
- Patient states increased comfort. (2,3)
- Oral mucous membranes are pink and moist. (1,2,3,4,5,6)
- Complications are avoided or minimized. (1,2,3)
- Patient correlates precipitating factors with appropriate oral care. (5,6)
- Patient demonstrates oral hygiene practices. (4)

Interventions and rationales

1. Inspect patient's oral cavity every shift. Describe and document condition; report any change in status. *Regular assessments can anticipate or alleviate problems.*
2. Perform prescribed treatment regimen, including administering I.V. or oral fluids, to improve condition of patient's mucous membranes. Monitor progress, reporting favorable and adverse responses to treatment regimen. ‡
3. Provide supportive measures, as indicated:
 - a. Assist with oral hygiene before and after

meals to promote feeling of comfort and well-being.

- b. Use a toothbrush with suction if patient cannot spit out water to minimize risk of aspiration.
 - c. Provide mouthwash or gargles, as ordered, to increase patient comfort and maintain moisture in mouth. ‡
 - d. Lubricate patient's lips frequently with water-based lubricant to prevent cracked, irritated skin.
4. Instruct patient in oral hygiene practices, if necessary. Have patient return demonstration of oral care routine. Tell patient to chew gum or suck on sugarless hard candy to stimulate salivation.
 - a. Use soft-bristled toothbrush.
 - b. Brush with circular motion downward from the gums.
 - c. Include the tongue when brushing.
 - d. Review need for routine visits to dentist (annually for adults). *These measures increase patient's awareness of oral hygiene practices and reduce discomfort, resulting in increased nutrition and hydration.*

5. Discuss precipitating factors, if known, and work to prevent future episodes. For example, encourage patient to avoid exercising in heat and to report effects of medication. *Patient's increased awareness of causative factors will help prevent recurrence.*
6. Encourage adherence to other aspects of health care management (controlling diabetes, changing dietary habits, avoiding alcoholic beverages) to control or minimize effects on mucous membranes.

Documentation

- Observations of condition, healing, and response to treatment
- Interventions to provide supportive care and patient's response to supportive care
- Instructions given, patient's understanding of instructions, and patient's demonstrated skill in carrying out prescribed oral care measures
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Oral mucous membrane alteration

related to mechanical trauma

100

Definition

Altered mouth integrity

Assessment

- History of oral surgery, dentures, braces, or dental problems
- Medications such as diuretics or antihistamines
- Vital signs
- Fluid and electrolyte status, including blood urea nitrogen, creatinine, intake and output, mucous membranes, serum electrolytes, skin turgor, urine specific gravity
- Oral status, including inspection of oral cavity (with gums and tongue), pain or discomfort, salivation
- Nutritional status, including current weight, change from normal weight, dietary pattern
- Psychosocial status, including coping skills, patient's perception of health problem, recent traumatic event

Defining characteristics

- Braces
- Decreased or absent salivation
- Dry mouth
- Halitosis
- Ill-fitting dentures
- Leukoplakia
- Oral lesions or ulcers
- Oral pain or discomfort
- Oral plaque

Associated medical diagnoses (selected)

Abscessed tooth, facial fracture, hemorrhagic gingivitis, impacted wisdom teeth, jaw fracture, other conditions requiring oral surgery

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient maintains fluid balance (intake equals output). (2)
- Oral mucous membranes are pink and moist. (1,2,3,4,5,6)
- Patient states increased comfort. (2,3,7)
- Complications are avoided or minimized. (1,2,3,7)
- Patient correlates precipitating factors with appropriate oral care. (5,6,7)
- Patient demonstrates correct oral hygiene practices. (4)

Interventions and rationales

1. Inspect patient's oral cavity every shift. Describe and document condition and report any status change. *Mechanical trauma can be caused by ill-fitting dentures, jagged teeth, braces, oral surgery, and insertion of endotracheal tube. Regular assessments can anticipate or alleviate problems.*
2. Establish and follow routine oral hygiene schedule. For example, soak dentures every evening, cleanse with denture cream, rinse, and keep in properly labeled container at patient's bedside. *Routine oral hygiene can im-*

prove condition of mucous membranes.

3. Provide supportive measures, as indicated:
 - a. Assist with oral hygiene before and after meals.
 - b. Use a toothbrush with suction if patient cannot spit out water.
 - c. Provide mouthwash or gargles, as ordered, *to increase patient comfort.* ‡
 - d. Lubricate patient's lips frequently with water-based lubricant. *Fluid and food intake increases when comfort is increased.*
4. Instruct patient in oral hygiene practices, if necessary. Have patient return demonstration of oral care routine. Tell patient to stimulate saliva by chewing gum or sucking on sugarless hard candy. *These measures increase patient's awareness of oral hygiene practices and reduce discomfort, resulting in increased nutrition and hydration.*
5. Discuss precipitating factors, if known, and work to prevent future episodes (for example, weight loss may change contours of oral cavity). *Patient's increased awareness of causative factors will help prevent recurrence.*
6. Encourage adherence to other aspects of

health care management *to control or minimize effects on mucous membranes.* For example, encourage patients with braces to avoid popcorn, chewing gum, caramels. *These measures reduce risk of trauma to oral mucous membrane.*

7. Refer patient to dentist, dental hygienist, or other appropriate resource to correct ill-fitting dentures, modify braces, adjust jaw wires, etc. *Regularly scheduled dental follow-up reduces risk of trauma to oral mucous membranes.* ‡

Documentation

- Observations of condition, healing, and response to treatment
- Interventions to provide supportive care and patient's response to supportive care
- Instructions given, patient's understanding of instructions, and demonstrated skill in carrying out prescribed oral care measures
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Definition

Altered mouth integrity

Assessment

- History of oral cavity disorder or surgery
- Medication history
- Oral status, including condition of teeth, inspection of oral cavity (including gums and tongue), oral hygiene routine, pain or discomfort, palpation of buccal mucosa, salivation
- Nutritional status, including current weight, change from normal weight, dietary pattern, vitamin intake
- Psychosocial status, including coping skills, family or significant other, habits (smoking, alcohol intake), patient's perception of health problem, self-concept, stressors (finances, family, job)

Defining characteristics

- Carious teeth
- Clinical evidence of pathology affecting oral mucous membranes
- Coated tongue
- Decreased or absent salivation
- Desquamation
- Dry mouth
- Gum hypertrophy or recession
- Halitosis
- Hyperemia
- Inflammation of gums or mucous membranes
- Leukoplakia
- Oral edema, bleeding, exudates
- Oral lesions, vesicles, ulcers
- Oral pain or discomfort
- Oral plaque

Associated medical diagnoses (selected)

Aphthous ulcers, bleeding disorders, cardiovascular disease with anticoagulant therapy, carious teeth, dental surgery, fractured jaw, gingivitis (all types), head and neck cancer with irradiation or chemotherapy, leukemia, malnutrition, oral cancer, oral candidiasis, oral trauma, periodontal disease, scurvy, stomatitis, terminal cancer

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Lesions or wounds show improvement or heal. (1,2,4,5,6)
- Complications are avoided or minimized. (1,2,4,5,7)
- Patient voices increased comfort. (2,4,5)
- Patient demonstrates understanding of surgical measures. (5)
- Patient voices feelings about condition. (3,8)
- Patient explains oral care routine. (5,6)
- Patient demonstrates oral hygiene practices. (6)

Interventions and rationales

1. Inspect patient's oral cavity every shift. Describe and document condition, reporting any status change. *Regular assessment prevents recurrence or exacerbation of problems.*
2. Perform prescribed treatment regimen for the underlying pathologic condition. Report favorable and adverse responses to treatment regimen. *Treating underlying condition improves condition of oral mucous membranes. ‡*
3. Encourage patient to state feelings and concerns about oral condition and its impact

on body image, *to help him accept changes in body image.*

4. Provide supportive measures as indicated:
 - a. Assist with oral hygiene before and after meals. Use soft-bristled toothbrush or cotton applicator and nonalcoholic mouthwash, *to minimize trauma to damaged tissues.*
 - b. Lubricate patient's lips frequently *to prevent cracking and irritation.*
 - c. Use artificial saliva solution if mouth remains dry *to restore normal moisture.*
 - d. Avoid serving hot, cold, spicy, fried, or citrus foods, *which irritate damaged tissue.*
 - e. Suction oral cavity to prevent drooling and aspiration of accumulated secretions. *Aspiration may lead to pneumonia or coughing and further trauma.*
 - f. To reduce pain, give soft or pureed foods, *which don't irritate tissues.*
5. If oral surgery is scheduled, give appropriate preoperative and postoperative instruction and care. Document response. *Instruction enhances compliance with therapy.*

6. Instruct patient in oral hygiene practices and have patient give return demonstration. Suggest referral to dentist or dental hygienist. *This increases patient's awareness of oral hygiene and reduces discomfort, resulting in increased nutrition and hydration. ‡*
7. Encourage patient to stop smoking. *Smoking has been linked to mucous membrane breakdown and cancer.*
8. Refer to psychiatric liaison nurse or support group, *to help patient cope with altered body image.*

Documentation

- Patient's expression of concern about oral condition and its impact on body image
- Patient's willingness to join in own care
- Observations of condition, healing, and response to treatment
- Interventions to provide supportive care and patient's response to supportive care
- Instructions given, patient's understanding of instructions, and demonstrated skill in carrying out prescribed oral care measures
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Definition

Subjective sensation of discomfort derived from multiple sensory nerve interactions generated by physical, chemical, biological, or psychological stimuli

Assessment

- Descriptive characteristics of pain, including location, quality, intensity on a scale of 1 to 10, temporal factors, sources of relief
- Physiologic variables, such as age and pain tolerance
- Psychological variables, such as body image, personality, previous experience with pain, anxiety, and secondary gain
- Sociocultural variables, including cognitive style, culture or ethnicity, attitude and values, sex, and birth order
- Environmental variables, such as the setting and time

Defining characteristics

- Alteration in muscle tone (may range from listless to rigid)
- Autonomic responses not seen in chronic stable pain (diaphoresis, blood pressure and pulse rate change, dilated pupils, and increased or decreased respiratory rate)
- Communication (verbal or coded) of pain description
- Distracting behavior, such as moaning, crying, and seeking out other people or activities
- Facial mask of pain, characterized by lackluster eyes, a "beaten" look, fixed or scattered movement, or grimacing
- Guarding or protective behavior, such as favoring a body part
- Narrowed focus, including altered time perception, withdrawal from social contact, and impaired thought process
- Self-focusing

Associated medical diagnoses (selected)

Pain can be experienced with most medical diagnoses. The following represent diagnoses in which pain is severe: angina pectoris, burns, migraine headache, myocardial infarction, pancreatitis, renal colic, thoracic surgery

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient identifies pain characteristics. (1)
- Patient articulates factors that intensify pain and modifies behavior accordingly. (1,2,4)
- Patient expresses a feeling of comfort and relief from pain. (1,2,3,5,6,7)
- Patient states and carries out appropriate interventions for pain relief. (2,3,4,5,6,7,8)

Interventions and rationales

1. Assess patient's physical symptoms of pain and administer pain medication as prescribed. Monitor and record medication's effectiveness and side effects. *Assessment allows for care plan modification as needed.* ‡

2. Perform comfort measures to promote relaxation, such as massage, bathing, repositioning, relaxation techniques. *These measures reduce muscle tension or spasm, redistribute pressure on body parts, and help patient focus on non-pain-related subjects.*

3. Plan activities with the patient to provide distraction, such as reading, crafts, television, visits, etc., *to help patient focus on non-pain-related matters.*

4. Provide the patient with information to help

increase pain tolerance; for example, reasons for pain and length of time it will last. *This educates patient and encourages compliance in trying alternative pain relief measures.*

5. Manipulate the environment to promote periods of uninterrupted rest. *This promotes health, well-being, and increased energy level important to pain relief.*

6. Apply heat or cold as ordered (specify) *to minimize or relieve pain.* ‡

7. Help patient into a comfortable position and use pillows to splint or support painful areas, as appropriate, *to reduce muscle tension or spasm and to redistribute pressure on body parts.*

8. Collaborate with patient in administering prescribed analgesics when alternative methods of pain control are inadequate. *Gaining patient's trust and involvement helps ensure compliance and may reduce medication intake.* ‡

Documentation

- Patient's description of physical pain, pain relief, and feelings about pain
- Observations of patient's physical, psycho-

logical, and sociocultural responses to pain

- Comfort measures and medications provided to reduce pain; also effectiveness of interventions

- Information provided to patient about pain and pain relief

- Other interventions performed to assist patient with pain control

- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Definition

Subjective sensation of discomfort derived from multiple sensory nerve interactions generated by physical, chemical, biological, or psychological stimuli

Assessment

- History of exposure to physical, biological, or chemical agents as a cause of pain
- Descriptive characteristics of pain, including location, quality, intensity on a scale of 1 to 10, temporal factors, and sources of provocation or relief
- Physiologic variables, such as age and pain tolerance
- Psychological variables, such as body image, personality, previous experience with pain, anxiety, and secondary gain
- Sociocultural variables, including cognitive style, culture and ethnicity, attitude and values, sex, and birth order

- Environmental variables, such as time and setting

Defining characteristics

- Absence or insufficient levels of physical, biological, or chemical agents to cause pain intensity experienced by patient
- Communication (verbal or coded) of pain description
- Distracting behavior, such as moaning, crying, pacing or restlessness, or seeking out other people or activities
- Facial mask of pain, including lackluster eyes, a "beaten" look, fixed or scattered movement, grimacing, and altered muscle tone (may range from listless to rigid)
- Guarding or protective behavior, such as favoring a body part
- Narrowed focus, including altered time perception, withdrawal from social contact, and impaired thought processes

- Pattern of pain described by patient that's difficult to associate with a physiologic process

Associated medical diagnoses (selected)

Depending on the variables present in assessment, such psychological agents as stress, depression, and ineffective coping mechanisms may intensify pain caused by physical, biological, or chemical agents. An example of psychological pain is the phantom pain often experienced following limb amputation.

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS and RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient identifies specific characteristics of pain. (1,2,3)
- Patient expresses relief from pain within a reasonable time after taking prescribed medication. (2)
- Patient helps develop a plan for pain control. (3,4)
- Patient articulates possibility of physical pain being associated with emotional stressors. (3)
- Patient requires less pain medication (specify). (4,5,6)
- Patient states satisfaction with pain management regimen. (1,2,3,4,5,6,7)
- Patient utilizes available resources to understand pain phenomenon and cooperates with treatment plan. (4,5,7,8)

Interventions and rationales

1. Assess physical symptoms that require pain medication and administer medication as prescribed. *Continuous reassessment documents patient's subjective complaints and behavior with organic pathology.* ‡
2. Return to patient in 30 minutes to check medication's effectiveness. *This establishes*

trusting-caring relationship that encourages accurate communication.

3. Discuss with patient possible association between exacerbation of pain and patient's identified stressors. *This helps patient explore exacerbating emotional or environmental factors that may affect pain.*

4. Ask patient to help establish goals and develop plan for pain control. *This gives patient sense of control.*

5. Provide patient with positive feedback about progress toward reaching goals *to improve motivation and encourage compliance.*

6. Spend at least 15 minutes per shift allowing patient to express feelings, *which will help give patient a sense of control.*

7. Consider the services of a psychiatric mental health professional to help patient and staff establish a realistic plan to resolve the problem. *Patients who remain helpless, unmotivated, uncooperative, and manipulative are self-destructive. Underlying causes should be explored.* ‡

8. Plan activities to distract patient, such as reading, television, visits, etc. *to help patient focus on matters other than pain.*

Documentation

- Patient's expressions of physical pain and well-being, and emotional pain and well-being
- Observations of patient's physical well-being
- Interventions performed to assist patient in controlling pain
- Results of interventions
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Definition

Pain complaints that last longer than the expected healing process, which is usually 6 to 12 weeks

Assessment

- Descriptive characteristics of pain, including location, quality, intensity on a scale of 1 to 10, temporal factors, duration, precipitating factors (food, alcohol, activity, stress), comfort factors
- Physiologic variables, such as general health state, length of pain, organ system involvement, pain tolerance, disability (work, family, social), pain interventions (injection, traction, ice, physical therapy, transcutaneous electrical nerve stimulation [TENS])
- Psychological variables, such as age, self-esteem, self-worth, role (worker, husband, breadwinner), coping behavior (appropriate or inappropriate), secondary gains (disability insurance, workmen's compensation, litigation),

suffering (emotional component), manipulative behavior, dependence on others or on system, previous hospital experience

- Sociocultural variables, including educational level, motivation, culture or ethnicity, sex, values and beliefs, pain behaviors, financial distress, religion
- Environmental variables, such as setting and time
- Pharmacologic variables, including type of drugs, amount used in one day, use of illicit drugs, and use of alcohol

Defining characteristics

- Autonomic responses generally absent
- Communication (verbal or coded) of pain description
- Demands for immediate relief
- Fatigue
- GI concerns or problems
- Insomnia
- Muscle tone alteration; spasm

- Narrowed perception and awareness of surroundings
- Pain behavior: crying, moaning
- Protective behavior: guarding, limping
- Self-focusing
- Sexual dysfunction
- Weight gain or loss

Associated medical diagnoses (selected)

Cervical pain, chronic low back pain, diabetic neuropathy, intermittent or chronic headaches, phantom limb, postherpetic neuralgia, postsurgical pain, reflex sympathetic dystrophy

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient identifies characteristics of pain and pain behaviors. (1)
- Patient develops a pain management program that includes activity and rest schedule, exercise program, and medication regimen that's not pain-contingent. (2,3,4,5,6)
- Patient carries out resocialization behavior and activities. (2)
- Patient states relationship of increasing pain to stress, activity, and fatigue. (6,7,8)
- Patient states importance of self-care behavior or activities. (7)

Interventions and rationales

1. Assess patient's physical symptoms of pain, physical complaints, and daily activities. Administer pain medication as prescribed. Monitor and record effectiveness and adverse effects of medication. (Keep in mind that pain behavior and pain talk may be inconsistent.) *Correlating patient's pain behavior with activities, time of day, and visits may be useful in modifying tasks.* ‡
2. Develop behavior-oriented care plan, follow-

ing activity schedule, for example. *Learned pain behaviors must be modified through behavioral-cognitive measures.*

3. Instruct patient in use of relaxation techniques, music, or therapy to relieve pain, as adjunct to medications; also to increase self-help and foster independence.

4. Teach patient and family such techniques as massage, use of ice, or exercise to relieve pain and foster independence.

5. Work closely with staff and patient's family to achieve pain management goals and maximize patient's cooperation.

6. Use behavior modification; for example, spend time with patient only if discussion includes no pain talk. Use contingency rewards for decreasing pain talk and pain behavior. *Reducing pain talk helps patient refocus on other, more important, matters.*

7. Encourage self-care activities. Develop a schedule. *This helps patient gain sense of control and reduces dependence on caregivers and society.*

8. Establish a specific time to talk with patient about pain and its psychological and emo-

tional effects to establish a trusting, supportive relationship encompassing patient's biopsychosocial, sexual, and financial concerns.

Documentation

- Patient's description of physical pain, pain relief, and feelings about pain
- Pain talk and pain behavior and affect
- Relationship of reports of pain to activities
- Treatments and pain talk
- Time out of bed
- Comfort measures initiated by nurse, patient, or family
- Response to interventions
- Response to pharmacologic agents
- Interaction with staff
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Definition

State in which one or both parents experience role confusion and conflict in response to crisis

Assessment

- Parental status, including age and maturity; apprehension, fear, guilt; coping mechanisms employed; developmental state of family and other children; knowledge of normal growth and development of children; parents' past response to crises; parents' understanding of child's present condition; previous parent-child relationship; spiritual practices of parents and family; stability of parental relationship; support systems available to parent
- Parent-child interaction, including eye contact, response to appearance (bandages, deformities, hospital equipment), smiling, touching, verbalization

Defining characteristics

- Change in parent-child interaction (speaking and listening, touch, visual contact)
- Ineffective parental coping mechanisms
- Parental relationship breakdown; decreased mutual support and communication
- Parental role changes
- Parents unable or unwilling to participate in child's physical or emotional care

Associated medical diagnoses (selected)

Any disease or condition, short-term or long-term, that results in a child's hospitalization

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Parents communicate feelings about present situation. (4,7,8)
- Parents become involved in normal caretaking of their child. (1,2,5,6)
- Parents express feelings of greater control and ability to offer more in present situation. (1,2,4,6,7,8)
- Parents express knowledge of child's developmental needs. (2,3)
- Parents fill an integral role during child's hospitalization and are able to meet child's physical and emotional needs during time of crisis. (2,3,5,6,7)
- Parents use available support systems or agencies to assist in coping. (4)

Interventions and rationales

1. Orient parents and significant others to hospital environment, visiting procedures, apparatus, and staff. *Knowledge of physical layout, staff, and institution policies helps allay anxiety.*
2. Encourage and involve parents in caring for their child *to decrease feelings of helplessness.*

3. Educate parents in normal childhood physical and psychological development. *This knowledge can prepare parents for changes.*
4. Encourage parental involvement in appropriate support groups or agencies when necessary. *Such groups can provide emotional support and help reduce feelings of being overwhelmed.*
5. Encourage questions about child's status *to lessen feelings of helplessness.*
6. Involve parents in child's case conference, if and when appropriate. *Active participation increases feelings of involvement and control.*
7. Facilitate open communication between parents to express feelings of guilt, blame, helplessness, anger, fear, frustration, etc. *Expression can help reduce anxiety and tension.*
8. Explore and review effective coping techniques *to further reduce anxiety.*

Documentation

- Observations of parents' ability to cope; their level of involvement in current situation
- Interventions performed to assist parents in

lowering stress and ultimately in coping with situation

- Referrals to outside agencies or support groups
- Child's medical and emotional state
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

Definition

Inability of a nurturing figure to promote optimum growth and development in an infant or child

Assessment

- Parental status, including age or maturity; age, sex, status of other children; apprehension; developmental state; family and friends; history of hereditary disease; knowledge of child care, normal growth and development; previous bonding history; relationship with spouse or significant other
- Infant-child-parent interaction, including care practices; eye contact; response to appearance, handicaps, sex of infant; smiling; touching; verbalization; visual and voice responses
- Psychosocial status, including financial stressors, previous experience; support of family, friends, significant other; work demands

Defining characteristics

- Constant verbalization of disappointment in sex or physical characteristics of infant or child
- Evidence of physical and psychological trauma
- Failure to thrive
- Growth and development lag in infant or child
- History of child abuse or abandonment by primary caretaker
- Inappropriate caretaking behaviors (toilet training, sleep and rest, feeding)
- Inattention to infant's or child's needs
- Lack of parental attachment behaviors: inappropriate visual, tactile, auditory stimulation; negative attachments of meanings to characteristics of infant or child; negative identification of characteristics of infant or child
- Noncompliance with health appointments for self and infant or child
- Verbalization of inability to control child

- Verbalization of resentment toward infant or child
- Verbalization of role inadequacy

Associated medical diagnoses (selected)

Pregnancy (cesarean section, full-term, multiple or premature births), hospitalization (acute, planned, unexpected)

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient establishes eye, physical, and verbal contact with infant or child. (2,3,6)
- Patient voices satisfaction with infant or child. (7)
- Patient demonstrates correct feeding, bathing, and dressing techniques. (1,2,3,4,5,6)
- Patient maintains relationship with spouse or significant other. (2,7)
- Patient states plans for routine physical and psychological examinations for infant. (4)

Interventions and rationales

1. Orient parents to environment, visiting policies, and child-care classes. *Knowledge of physical layout and institutional policies helps allay anxiety.*
2. Involve parents in care of infant or child immediately *to establish bonding.*
3. Provide opportunities for caretaking by allowing parents to share room with infant or child or by extending visitation periods. *This increases feelings of self-esteem and self-worth.*
4. Educate parents in:
 - a. normal growth and development.

- b. feeding techniques: breast, bottle.
- c. infant care, such as bathing, dressing.
- d. signs and symptoms of illness.
- e. need for tactile and sensory stimulation.
- f. routine medical follow-up.

Knowledge of routine infant care will increase chances of successful parenting.

5. Encourage questions about caretaking and provide appropriate information *to allay anxiety and monitor knowledge retention.*

6. Refer parents to family support group if difficulties in adapting are identified *to enhance adaptation.*

7. Encourage verbalization of infant's or child's impact on family life. *Changes in family plans and routines may occur; discussion helps establish satisfactory compromise.*

Documentation

- Parent's expressions of feelings about current situation
- Observations of bonding, caretaking, and knowledge level
- Instructions given
- Infant's weight
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

Definition

Presence of risk factors which may interfere with a parent's ability to promote optimum growth and development in an infant or child

Assessment

- Ages of mother and child
- Mother's psychosocial status, including developmental state; educational level; family roles; presence or absence of spouse or significant other; financial stressors; previous parenting experience; support of family, friends, or significant other; work demands
- Interaction between mother and infant or child, including care practices; eye contact; response to appearance and sex of infant; smiling; touching; verbalization; and visual and voice responses

Risk factors

- Delay in growth and development of infant or child
- Failure to thrive
- Frequent accidents
- Lack of knowledge of appropriate parenting activities
- Lack of parental attachment behaviors
- Mother expresses frustration, anger, sadness, or disappointment over problems in caring for infant or child
- Mother fails to comply with health appointments for self and infant or child
- Mother fails to provide appropriate visual, tactile, or auditory stimulation
- Mother not attentive to infant's or child's needs
- Mother unfamiliar with appropriate caretaking behaviors in areas such as toilet training, sleep, or feeding

Associated medical diagnoses (selected)

Burns, failure to thrive, fractures, head trauma, neglect, soft tissue injuries

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Mother establishes eye, physical, and verbal contact with infant or child. (3,8)
- Mother demonstrates correct feeding, bathing, and dressing techniques. (2,7,8)
- Mother states plans for bringing infant or child to clinic for routine physical and psychological examinations. (6,8,9,10)
- Mother expresses understanding of developmental norms. (4,7,8)
- Mother provides play activities appropriate to child's age. (1,5,8)

Interventions and rationales

1. Assess the amount of developmental stimulation provided by mother. For example, use Caldwell HOME Inventory Measure on home visit *to assess presence or absence of developmentally stimulating home environment.*
2. Instruct mother in basics of infant and child care, including:
 - a. breast and bottle-feeding techniques, such as positioning of infant for optimal intake, amount to offer at each feeding, and frequency of feedings based on infant's age

- b. bathing and safety precautions during bathing
- c. appropriate dressing.

Research shows that the primary source of information about parenting is the mother's own parents. If the mother lacks an effective role model, you may need to supply basic information about parenting.

3. When caring for the child in the mother's presence, act as a role model of effective parenting skills. Demonstrate comfort measures, such as rocking the infant, and show mother how to hold the infant in an en face position *to increase mother's knowledge of routine child-care practices.*
4. Teach the mother about normal growth and development, and identify ages at which child is able to master developmental tasks such as rolling over, crawling, and walking. *This will assist mother in monitoring child's growth and development and in practicing appropriate safety precautions, such as blocking stairways, keeping crib side rails secured, and preventing accidents.* Also discuss problem behaviors associated with specific ages, such as colic, temper tantrums, and sleeping diffi-

culties to further enhance mother's understanding of developmental norms.

5. Discuss child's need for tactile and sensory stimulation. Demonstrate play activities that promote developmental skills, such as shaking a rattle in front of the infant to build eye-and-hand coordination, or placing a mobile above the infant to encourage visual tracking and trunk and head control. *Sensory experiences promote cognitive development.*

6. Familiarize the mother with techniques for detecting symptoms of illness in infant or child, including:

- a. taking temperatures and reading thermometers
- b. assessing child's respiratory status
- c. observing for behavioral cues of illness, such as increased crying, rubbing ears, or drawing legs to abdomen.

Knowledge of how to monitor child's health status will assist in diagnosis and early treatment of problems.

7. Encourage mother to ask questions about infant and child care. Identify questions parents commonly ask about infant care, such as

(continued)

† Numbers following outcomes refer to interventions.

Interventions and rationales (continued)

cord care, feeding techniques, and bathing. Reassure mother that other parents also need to ask basic questions. *A mother who lacks effective parenting role models may not know what questions to ask or she may hesitate to ask questions because of embarrassment.*

8. Praise mother when she displays appropriate parenting skills *to provide positive reinforcement.*

9. Emphasize the importance of making regular visits to a health care professional, even when the child appears healthy. *Routine visits are important for early detection of developmental delays, as well as preventive care such as immunizations.*

10. As necessary, refer mother and family to doctor or social services for follow-up *to ensure continuity of care.*

Documentation

- Evidence of neglect of infant or child
- Observations of mother's caretaking skills and knowledge level
- Presence or absence of mother-child bonding behaviors
- Questions asked by mother about care of infant or child
- Instructions given to mother, and mother's response
- Evaluations for each expected outcome.

Care plan notes

Care plan notes

Definition

Accentuated risk of disruption in circulation or sensation in an extremity or motion of an extremity

Assessment

- History of trauma or vascular injuries
- Inspection of extremities, including signs of soft-tissue injury such as abrasions, lacerations, contusions
- Pain sensation, including characteristics (sharp, dull, constant, intermittent), precipitating factors, reaction to passive stretching of affected muscles
- Tactile sensation in upper extremities, including deltoid, radial side of forearm, palmar surface of thumb, fingers, palmar surface of little finger, webbed space between thumb and index finger
- Tactile sensation in lower extremities, including medial side of foot and leg, medial side of thigh, sole of foot, lateral aspect of leg below

the knee

- Motor nerve function of the upper extremities, including arm abduction at the shoulder, arm flexion at the elbow, thumb and little finger opposition, abduction and adduction of fingers, extension of wrist and fingers
- Motor nerve function of lower extremities, including knee extension, thigh adduction, plantar flexion and dorsiflexion of ankle, flexion and extension of toes
- Pulses in upper and lower extremities, including radial, ulnar, brachial, femoral, popliteal, posterior tibial, and dorsalis pedis
 - a. bilateral comparison
 - b. quality using the following scale:
 - 0 = absent
 - 1 = very weak, barely palpable
 - 2 = weak, reduced
 - 3 = slightly weak, easily located
 - 4 = normal, easily located
- Vascular status, including capillary refill time, blanching, skin temperature, and skin color

- Point tenderness, especially over bony prominences
- Edema
- Increased intracompartmental pressure
- Cranial nerves (if patient has halo cast)

Risk factors

- Fractures
- Mechanical compression, such as tourniquet, cast, brace, dressing, or restraint
- Orthopedic surgery
- Trauma
- Immobilization
- Burns
- Vascular obstruction

Associated medical diagnoses (selected)

Carpal tunnel syndrome, compartment syndrome, ganglion cyst, neurovascular compression, peripheral nerve entrapment syndrome, vascular insufficiency, vascular occlusion

Expected outcomes †

- Patient does not experience disability related to peripheral neurovascular dysfunction following injury or treatment. (1,2,3,4,5,6,7,8,9,10,11,12,13,14,15)
- Patient maintains circulation in extremities. (2,3,4,5,6,7,8,10,12,13,14,15)
- Patient is able to feel and move each toe or finger following application of cast, splint, or brace. (3,4,5,6)
- Patient demonstrates correct body positioning techniques. (15)
- Patient or significant other expresses understanding of risk for altered neurovascular status and the need to report symptoms of impaired circulation. (16,17)
- If appropriate, patient enrolls in smoking cessation program. (11)

Interventions and rationales

1. Note if patient is to undergo surgery or procedure that increases his risk of peripheral neurovascular dysfunction *to anticipate complications.*
2. Immobilize joints directly above and below a suspected fracture site, leaving room for pulse

assessment *to facilitate monitoring of circulatory status.*

3. As appropriate, assess circulation before application of cast, brace, or splint. Following application of cast, splint, or brace, have patient move fingers and toes every 4 hours until discharge *to detect signs of impaired circulation.*
4. Remove clothing around suspected fracture site, clean site, apply sterile dressings to open wounds, and carefully apply splint, cast, or brace *to avoid further infection and trauma.*
5. Follow institutional guidelines for the application of devices such as tourniquets, restraints, and tape *to ensure adequate circulation in affected extremity.*
6. If you suspect nerve compression, assess position of extremity which has cast, splint, or brace. *Positioning of extremity may affect circulation.*
7. Elevate limb above heart level following surgery or trauma *to reduce risk of edema.* If increased intracompartmental pressure is evident, maintain affected limb at heart level *to reduce pressure.*
8. If edema appears in affected extremity,

split, bivalve, slit, or cut a window in the cast and padding, according to institutional protocol, *to avoid neurovascular impairment.*

9. Inject neurotoxic agents (such as penicillin G, hydrocortisone, tetanus toxoid, and diazepam) away from affected extremity and major nerves *to avoid injury.* ‡
10. Avoid flexing affected extremity. *Flexion may reduce venous circulation, thereby increasing risk of neurovascular complications.*
11. If patient smokes, encourage him to enroll in a smoking cessation program. *Quitting smoking may enhance oxygenation and thereby decrease risk of peripheral neurovascular dysfunction.*
12. Take steps to ease patient's anxiety. *Stress may lead to vasoconstriction.*
13. Administer and monitor effectiveness of vasodilators, as ordered, *to control vasospasm.* ‡
14. If patient requires fasciotomy to restore circulation, provide educational material which explains this emergency procedure *to reduce patient anxiety.*
15. Instruct patient or significant other in

(continued)

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Interventions and rationales (continued)

proper positioning when lying in bed and when sitting and in methods of obtaining pressure relief *to avoid pooling of blood and pressure ulcers.*

16. If appropriate, discuss cause of injury and safety precautions *to avoid further injury.* Injuries to the upper extremities are usually caused by industrial accidents; injuries to the lower extremities, by automobile accidents.

17. Instruct patient or significant other in recognizing signs and symptoms of peripheral neurovascular dysfunction, including numbness, pain, or tingling. Emphasize need to report symptoms to doctor *to prevent onset of neurovascular damage after discharge.*

Documentation

- Results of neurovascular assessment (baseline and ongoing)
- Nature of injury or treatment
- History of illnesses and surgeries

- Symptoms of neurovascular dysfunction reported by patient or significant other
- Patient's turning schedule
- Instructions provided to patient or significant other at discharge
- Evaluations for each expected outcome.

Care plan notes

Care plan notes

Definition

Uncertainty about components of self regarding choices of vocation, intimacy and life-style

Assessment

- Choices of vocation, sexual orientation, religious orientation, friendships
- Ability to defend choices regarding long-range goals, to recognize alternatives, and appreciate consequences
- Comfort level of decisions made regarding long-range goals
- Degree of anxiety or depression regarding long-range goals
- Loss of interest, or social isolation from usual activities or friends
- Level of irritability about long-range goals
- Sleep difficulties
- Changes in eating habits
- Family status, including method of dealing with general conflicts; level of patient's communication with parents; handling of negotia-

tions regarding restriction of freedom; degree of patient's separation from family; tolerance of patient's expressed opinions; age-appropriateness of dating, curfew regulation, money responsibilities; reaction of parents to patient's long-range goals

- Family and cultural standards related to separation issues

Defining characteristics

- Patient is distressed about uncertainties regarding variety of long-range goals, which may include vocation or career, relationships with friends, sexuality and sexual preferences, or religious affiliation
- Condition typically occurs in adolescence and young adulthood, but can occur later as well

Associated medical diagnoses (selected)

Identity disorder, adjustment reaction. Patient's disorder cannot result from major affective disorder, schizophrenia, or borderline personality disorder

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient establishes trusting relationship with caregiver. (1,2)
- Patient's issues are explored. (3,4,9)
- Family's issues are explored. (8)
- Patient establishes a firm, positive sense of self and personal identity. (4,7,9)
- Patient chooses long-range goals using problem-solving techniques and is comfortable with choices. (5,6,7,10)
- Family accepts patient's choices of long-range goals. (8,10)

Interventions and rationales

1. Assess patient alone, without family, to gather baseline data and begin therapeutic relationship.
2. Explain your role as patient advocate; negotiate rules of interaction, including confidentiality, depth and breadth of discussion. *This establishes your role as a resource to the patient rather than as family's agent.*
3. Explore personal identity issues distressing to patient to isolate issues into smaller units that can be more readily addressed.
4. Help patient identify values, beliefs, hopes,

dreams, skills, and interests. *Patient's deficits may lie in lack of self-exploration, problem-solving methods used, or separation issues with parents.*

5. Integrate personal identity issues into decisions and choices to develop skill in problem-solving methods.

6. Help patient identify likelihood and consequences of each choice. *Discussion and explanation aid problem-solving skills.*

7. Promote choices with best likelihood of success. *Specific instructions can help patient gain problem-solving ability and maturity.*

8. Encourage family conferences to explore potential reactions to patient's choices and promote support for patient's independent decision-making. *Meetings can help patient and family identify problems and find better ways to interact. Meetings also allow patient and family to ventilate true feelings in a safe environment.*

9. Encourage peer support groups to explore and share personal identity experiences. *Adolescents and young adults often accept peer groups more than adults.*

10. Promote outpatient counseling, family

meetings, and peer support groups as appropriate to reinforce progress. *Establishing outpatient support systems can reduce regression.*

Documentation

- Assessment of patient's initial issues and problem-solving ability, including family's reactions as well as assessment of level of separation achieved by patient
- Patient's level of emotional distress and changes in sleep and eating, initially and as hospitalization continues
- Patient's progress in problem-solving and making choices
- Patient-family interactions, and content of family meetings
- Patient's interaction in peer-group meetings
- Outpatient resources identified and suggested to patient and family
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

Definition

Accentuated risk of accidental exposure to or ingestion of drugs or dangerous products in doses sufficient to cause poisoning

Assessment

- Health history, including accidents, allergies, exposure to pollutants, falls, hyperthermia, hypothermia, poisoning, sensory or perceptual changes (auditory, gustatory, kinesthetic, olfactory, tactile, visual), trauma
- Circumstances surrounding the present situation that might lead to injury
- Neurologic status, including level of consciousness, mental status, orientation
- Psychosocial history, including age, habits (drug, alcohol use), occupation, personality
- Laboratory studies, including clotting factors, hemoglobin and hematocrit, platelet count, white blood cell count, toxicology screening

Risk factors

- Dangerous products stored or placed within the reach of children
- Large supplies of drugs in the environment
- Medicines stored in unlocked cabinets and accessible to confused persons
- Poisonous plants with prominent leaves or berries that entice handling and ingestion

Associated medical diagnoses (selected)

Alzheimer's disease, brain tumor, cerebrovascular accident, chronic obstructive pulmonary disease, depression with suicidal ideation or inclination, drug overdose, organic brain syndrome, posttraumatic head injury

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient is not exposed to and does not ingest dangerous substances. (1,2,3,4,5,6)
- Patient communicates an understanding of need for self-protection. (7)
- Patient and family or significant other state method for safekeeping of dangerous or potentially dangerous products. (7)

Interventions and rationales

1. Observe, record, and report falls, seizures, and unsafe practices *to ensure implementation of appropriate interventions. Overdose of certain medications (for example, phenothiazines) can cause such neurologic problems as convulsions or seizures.*
2. Monitor and record respiratory status *because certain poisons can cause respiratory depression.*
3. Monitor and record neurologic status *because excessive toxic exposure can cause coma.* Pupils may be pinpoint or dilated, depending on type of drug ingested and length of time patient has been hypoxic.
4. Monitor vital signs, intake and output, and

level of consciousness. Record and report any changes. *Severe hypotension may develop following overdose. It may be related to central nervous system defect, direct myocardial depression, or vasodilation. Marked hyperthermia can occur with salicylate overdose, which affects metabolic rate. Dehydration may develop in some patients from increased respiratory rate, sweating, vomiting and urine losses.*

5. Remove all dangerous or potentially dangerous products from the environment *to avoid injury.*

6. Check settings on oxygen flow meters every ½ hour on all patients known to be CO₂ retainers (for example, certain patients with chronic obstructive pulmonary disease). *This avoids CO₂ narcosis from excessive O₂ therapy in poorly ventilated patients; if unchecked, patient may stop breathing.*

7. Provide patient and family or significant other with information about such specific products as medications, oxygen, and total parenteral nutrition. Tailor instructions to specific product and patient's capability for learning self-care. *This enables patient and family*

or significant other to identify and alter environmental or life-style factors to achieve optimum health level.

Documentation

- Patient's statements that indicate potential for injury
- Physical findings
- Observations or knowledge of unsafe practices
- Interventions performed to prevent injury
- Patient's response to nursing interventions
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

Definition

Accentuated risk of accidental exposure to or ingestion of drugs or dangerous products in doses sufficient to cause poisoning

Assessment

- Health history, including accidents, allergies, exposure to pollutants, falls, hyperthermia, hypothermia, poisoning, seizures, trauma, sensory-perceptual changes (auditory, gustatory, kinesthetic, olfactory, tactile, visual)
- Circumstances of present situation that might lead to injury
- Neurologic status, including level of consciousness, mental status, orientation
- Psychosocial history, including age, habits (drug, alcohol use), occupation, personality
- Laboratory studies, including clotting factors, hemoglobin and hematocrit, platelet count, white blood cell count, toxicology screening

Risk factors

- Cognitive or emotional difficulties
- Lack of proper precautions
- Lack of safety or drug education
- Reduced vision
- Verbalization of unsafe environment

Associated medical diagnoses (selected)

Alzheimer's disease, brain tumor, cerebrovascular accident, depression with suicidal ideation or inclination, mental retardation, organic brain syndrome, posttraumatic head injury, schizophrenia

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient is not exposed to and does not ingest dangerous products. (1,2,3,4,5)
- Patient communicates understanding of the need for self-protection. (6)
- Patient and family or significant other explain method for safekeeping of dangerous products. (6)

Interventions and rationales

1. Observe, record, and report falls, seizures, and unsafe practices *to ensure implementation of appropriate interventions. Overdose of certain medications can cause such neurologic problems as convulsions or seizures.*
2. Monitor and record respiratory status *because certain poisons can cause respiratory depression.*
3. Monitor and record neurologic status *because excessive toxic exposure can cause coma. Pupils may be pinpoint or dilated, depending on type of drug ingested and length of time patient has been hypoxic.*
4. Remove dangerous or potentially dangerous products from the environment *to avoid injury.*

5. Monitor vital signs, intake and output, and level of consciousness. Record and report any changes. *Severe hypotension may develop following overdose. It may be related to central nervous system defect, direct myocardial depression, or vasodilation. Marked hyperthermia can occur with salicylate overdose, which affects metabolic rate. Dehydration may develop in some patients from increased respiratory rate, sweating, vomiting, and urine losses.*
6. Provide patient or significant other with information about such specific products as medications, oxygen, and total parenteral nutrition. Tailor instructions to the specific product and the patient's capability for learning self-care. *This enables patient and family or significant other to identify and alter environmental or life-style factors to achieve optimum health level.*

Documentation

- Patient's statements about the situation that indicate potential for injury
- Physical findings
- Record of falls, seizures, and unsafe practices

- Interventions that reduce risk of injury
- Patient's response to nursing interventions
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

Definition

Sustained painful response to an unexpected life event

Assessment

- History and circumstances of accident
- Physical injuries sustained, including cardiopulmonary, musculoskeletal, genitourinary, integumentary
- Neurologic status
- Emotional reactions, including grief reaction, self-concept, sleep pattern
- Cognitive reactions, including concentration, memory, orientation
- Behavioral reactions, including available support systems, clergy, coping patterns, family or significant other, problem-solving ability, social interactions

Defining characteristics

- Reexperience of trauma, including exaggerated startle response, excessive verbalization of traumatic event, flashbacks, hyperalertness, intrusive thoughts, nightmares
- Psychic numbing, including amnesia, constricted affect, confusion, difficulty with interpersonal relationships, impaired reality interpretation, phobia, poor impulse control

Associated medical diagnoses (selected)

This nursing diagnosis can occur in any hospitalized patient seriously injured by sudden, unexpected trauma, such as a motor vehicle accident, airplane crash, train derailment, or fall.

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient recovers or is rehabilitated from physical injuries to the extent possible. (1)
- Patient states feelings and fears related to traumatic event. (2)
- Patient expresses feelings of safety. (2)
- Patient uses available support systems. (2,3,4)
- Patient uses effective coping mechanisms to reduce fear. (2)
- Patient maintains or reestablishes adaptive social interactions with family or significant other. (3,4)

Interventions and rationales

1. Follow medical regimen to manage physical injuries. *Attention to physical needs remains primary, according to Maslow's hierarchy.* ‡
2. Provide emotional support:
 - a. Visit patient frequently *to reduce fear of being alone.*
 - b. Be available to listen, *to respond empathetically to patient's feelings.*
 - c. Accept and encourage statement of patient's feelings *to reassure patient that feelings are appropriate and valid.*

- d. Assure patient of safety and take measures needed to ensure it. *Frequent nightmares or flashbacks may cause patient to question safety of environment.*
 - e. Avoid care-related activities or environmental stimuli that may intensify symptoms associated with trauma (loud noises, bright lights, abrupt entrances to patient's room, painful procedures or treatment). *Environmental stimuli can easily intensify flashbacks to traumatic event.*
 - f. Reorient patient to surroundings and reality as frequently as necessary. *Post-trauma psychic numbing impairs orientation, memory, and reality perception.*
 - g. Instruct patient in at least one fear-reducing behavior, such as seeking support from others when frightened. *As patient learns to reduce fears, coping skills will increase.*
3. Support patient's family or significant other:
 - a. Provide time for them to express feelings.
 - b. Help them understand patient's reactions.

This reduces their anxiety and gives them a chance to help patient.

4. Offer referral to other support persons or groups, including clergy, mental health professionals, trauma support group. *Referrals help patient to cite sense of universality, reduce isolation, share fears, and deal constructively with feelings.* ‡

Documentation

- Patient's perception of traumatic event
- Observations of patient's behavior
- Observations of patient's social interaction with others
- Interventions
- Patient's responses to nursing interventions
- Referrals to other support persons or groups
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Definition

Sustained painful response to an unexpected life event

Assessment

- History and circumstances of assault
- Patient's perception of event
- Physical injuries sustained, including cardio-pulmonary, genitourinary, integumentary, musculoskeletal
- Neurologic status
- Emotional reactions, including grief reaction, self-concept, sleep pattern
- Cognitive reactions, including concentration, memory, orientation
- Behavioral reactions, including coping patterns, social interactions
- Available support systems

Defining characteristics

- Reexperience of trauma, including exaggerated startle response, excessive or minimal verbalization of traumatic event, flashbacks, hyperalertness, intrusive thoughts, nightmares, verbal reports of guilt and self-recrimination
- Psychic numbing, including confusion, constricted affect, difficulty with interpersonal relationships, impaired reality interpretation, phobia, poor impulse control

Associated medical diagnoses (selected)

This nursing diagnosis can occur in any hospitalized patient injured as a result of an alleged physical assault. Examples include battered wives, physically abused children and elderly persons, victims of gunshot wounds or stabbing, prisoners of war, and hostages.

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient recovers from physical injuries to the extent possible. (1)
- Patient states feelings related to alleged assault. (2)
- Patient expresses feelings of guilt. (2)
- Patient expresses feelings of physical safety. (2,3,4)
- Patient uses effective coping mechanisms to reduce fear. (5)
- Patient mobilizes support systems and professional resources as necessary. (7)
- Patient reestablishes and maintains adaptive interpersonal relationships. (6,7)

Interventions and rationales

1. Follow medical regimen to manage physical injuries. *This reduces anxiety as patient perceives body's ability to recover from injury.* ‡
2. Provide patient with psychological support:
 - a. Visit frequently to decrease patient's fear of being left alone and to encourage trusting relationship.
 - b. Be available to listen, to respond empathetically to patient's feelings.

- c. Accept patient's feelings and behaviors to reassure patient that they're appropriate and valid.
 - d. Reassure patient of safety and take appropriate measures to ensure it. *Patient's feelings of safety are compromised by fear of repeated assaults.*
3. Avoid care-related activities and environmental stimuli that may intensify symptoms (loud noises, bright lights, abrupt entrances to room, painful procedures or treatments). *Patient's traumatic experience may be intensified by misinterpreting procedures or environmental factors as repeated assaults.*
 4. Monitor mental status, reorienting patient to surroundings and interpreting reality as often as necessary. *This alleviates psychic numbing, a characteristic symptom of assault.*
 5. Instruct patient in at least one fear-reducing behavior, such as seeking support from others when frightened. *This helps patient gain sense of mastery over current situation.*
 6. Support family or significant others:
 - a. Provide time for them to express feelings.
 - b. Help them understand phases of crisis

and patient's reactions to them. *This reduces their anxiety by giving them a chance to help patient.*

7. Offer referral to community or professional resources, including clergy, mental health professional, social service, "Victims of Assault" support groups. *Referrals help patient to cite sense of universality, decrease isolation, share fears, and deal constructively with feelings.*

Documentation

- Patient's perception of event
- Observations of patient's verbal and nonverbal behaviors
- Observations of patient's interaction with others
- Interventions
- Patient's responses to nursing interventions
- Referrals to other support systems
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Definition

Loss of control over the ability to meet present and future needs for housing, food, and physical care

Assessment

- Circumstances leading to homelessness or displacement
- Available resources, including family, extended family, friends, community and social support, personal strengths
- History of homelessness, hospitalization, incarceration, migration, drug or alcohol dependency
- Mental status, including judgment, affect, coping abilities, evidence of psychotic thinking, delusions, or drug or alcohol intoxication
- Recent losses
- Living conditions, including safety, protection from exposure to elements, adequacy of clothing, vulnerability to abuse

Defining characteristics

- Apathy
- Decreased self-esteem
- Depression
- Expression of feelings of being victimized
- Expression of uncertainty about future
- Expressions of hopelessness, helplessness, anger, despair, and fear
- Evidence of increased stress, such as anxiety, somatic symptoms, inability to focus attention
- Inability to plan for future
- Loss of means to provide for basic needs related to any of the following factors:
 - a. inability to take action on own behalf
 - b. loss of benefits
 - c. loss of family and friends
 - d. poor work history
 - e. recent migration
 - f. release from prison

g. relocation to an area away from family and friends

- Recent loss of domicile
- Willingness to let others make decisions

Associated medical diagnoses (selected)

Drug or alcohol dependency, bipolar disorder, organic mental disorders, personality disorders, schizophrenia. This nursing diagnosis may also be associated with untreated physical conditions, such as diabetes and skin disorders, aggravated by the patient's limited access to care.

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient expresses feelings of powerlessness. (1)
- Patient expresses feelings associated with powerlessness, such as loss, anger, depression, and guilt. (1,2)
- Patient obtains emergency shelter, food, and health care. (2,3)
- Patient contacts appropriate health care agencies, mental health services, social service agencies, and community resources. (3,5)
- Patient begins making decisions about regaining resources. (4,5,6)
- Patient sets and attains a small goal each day. (4,5,6,7,8)
- Patient expresses a greater sense of control over some facet of life. (1,4,5,6,7,8)
- Patient responds positively to emotional support offered by nurses and social services staff. (1,2,4,6,7)

Interventions and rationales

1. Encourage the patient to express feelings by establishing a trusting relationship *to enhance the patient's self-worth.*
2. Help the patient clarify needs and priorities *to reduce feelings of being overwhelmed.*

3. Contact appropriate emergency shelter programs, soup kitchens, and social service agencies, including public welfare agencies that provide income assistance, medical assistance, and food stamps. *According to Maslow's hierarchy, such needs as shelter, food, and safety must be addressed first.*

4. Assist the patient in identifying personal strengths and coping strategies used successfully in the past *to enhance self-esteem as well as sense of control and competence.*

5. Help the patient identify alternative sources of support, such as church and community groups, extended family, alcoholics anonymous, abused women's shelter, state employment counseling services, and veteran's assistance services. *The homeless patient may be cut off from family and friends and unfamiliar with community resources.*

6. Encourage the patient to participate in all aspects of care, including meeting physical and hygiene needs and contacting appropriate social service agencies *to empower the patient and enhance self-esteem.*

7. Instruct the patient in problem-solving skills and enhancing personal appearance, including

how to improve dress and hygiene. Prepare the patient for contact with social service agency personnel through role playing and written instruction. *Preparatory measures enhance self-esteem and encourage the patient to take an active role, which is essential in combating powerlessness.*

8. Encourage the patient to take small steps to regain control of life one day at a time. Help the patient to set manageable goals and then take steps to achieve them *to prevent the patient from becoming paralyzed by focusing on overwhelming problems.*

Documentation

- Patient's history of homelessness
- Patient's description of hardships and needs
- Patient's expressions of strengths and limitations
- Signs and symptoms indicating need for further health assessment
- Interventions to assist patient
- Contact with social service agencies on behalf of patient
- Patient's response to nursing interventions
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

Definition

Perceived loss of control over what happens to oneself and one's environment

Assessment

- Nature of medical diagnosis
- Mobility
- Behavioral responses (verbal and nonverbal), including calmness, agitation, anger, independence or dependence, interest or apathy, satisfaction or dissatisfaction
- Past experiences with hospitalization
- Environment, including equipment and supplies, health care professionals and personnel, lighting, location of patient's personal belongings, noise, privacy, space
- Knowledge, including current understanding of physical condition; physical, mental, emotional readiness to learn

Defining characteristics

- Apathy
- Dependence on others that may result in irritability, anger, resentment, guilt
- Depression over physical deterioration that occurs despite compliance with regimens
- Expressions of dissatisfaction and frustration over inability to perform previous tasks or activities
- Fear, sadness, crying
- Passivity
- Reluctance to express true feelings, fearing alienation from caregivers
- Verbal expressions of having no control over situation
- Verbal expressions of having no control or influence over self-care

Associated medical diagnoses (selected)

Acute respiratory failure, burns, cardiac disease that requires pacemaker, cerebrovascular accident, chronic obstructive pulmonary disease, chronic renal failure, hemodialysis, peritoneal dialysis, insulin-dependent diabetes; neoplastic diseases requiring chemotherapy or radiation; diseases requiring organ transplantation, spinal cord injury

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient acknowledges feelings of powerlessness over regimen. (1,2)
- Patient participates in planning care. (3)
- Patient participates in self-care activities (specify). (4)
- Patient enumerates factors in the illness-related regimen over which control can be maintained. (5,6)
- Patient demonstrates ability to plan for controllable factors. (6)
- Patient communicates a sense of having regained control. (7,8)

Interventions and rationales

1. Encourage patient to express feelings about present situation. *This helps patient bring vaguely expressed emotions into clear awareness and acceptance.*
2. Accept patient's feelings of powerlessness as normal. *This indicates respect for patient and enhances patient's feelings of self-worth.*
3. Allow patient to make decisions about care (positioning, times for ambulation). *This helps patient maintain a sense of control and re-*

duces potential for maladaptive coping behaviors.

4. Encourage participation in self-care. Provide positive reinforcement for patient's activities. *This enhances patient's sense of control and reduces passive and dependent behavior.*
5. Begin teaching patient how to regain and maintain optimal health. *In this teaching relationship, the nurse presents information to the patient on a need-to-know basis.*
6. Help identify specific areas where patient can maintain control to *reduce patient's feelings of helplessness.*
7. Have patient demonstrate ways to consciously maintain some degree of control. *Repetitive demonstrations of skills and behaviors enhance learning.*
8. Help patient learn as much as possible about present health problem. *The greater the understanding, the more the patient will feel in control.*

Documentation

- Patient's expressions of powerlessness
- Patient's behaviors that evidence a feeling of powerlessness
- Interventions performed to assist patient in regaining sense of control
- Patient's degree of participation in planning care
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

Definition

Perceived loss of control over what happens to oneself and one's environment

Assessment

- Nature of the medical diagnosis
- Mobility
- Behavioral responses (verbal and nonverbal), including calmness, agitation, anger, independence or dependence, interest or apathy, satisfaction or dissatisfaction
- Usual coping strategies
- Past experiences with hospitalization
- Knowledge, including current understanding of physical condition; physical, mental, emotional readiness to learn
- Environment, including equipment and supplies, health care professionals and personnel, lighting, location of patient's personal belongings, noise, privacy, space

Defining characteristics

- Apathy
- Dependence on others that may result in irritability, anger, resentment, guilt
- Discomfort or dissatisfaction with health care environment
- Expressions of dissatisfaction and frustration over inability to perform previous tasks or activities
- Expressions of doubt regarding role performance
- Fear, sadness, crying
- Passivity
- Verbal expressions of having no control or influence over situation
- Verbal expressions of having no control or influence over self-care

Associated medical diagnoses (selected)

This diagnosis is best identified by considering problems that restrict or confine patients rather than by medical diagnosis. Examples include blindness, confinement to an intensive care or cardiac care unit, isolation, language barrier, multiple I.V. lines, multisystem trauma, and restrictions caused by dependence on ventilators, paralysis, traction

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient identifies feelings of powerlessness associated with the environment. (1)
- Patient describes modifications or adjustments to the environment that allow feelings of control. (2,3,4)
- Patient participates in self-care activities (specify). (5,6,7)
- Patient states feelings of regained control. (4,5,6,7,8)

Interventions and rationales

1. Visit with patient 15 minutes each shift *to allow patient to express concerns and feelings.*
2. Acknowledge the importance of patient's space:
 - a. Verbally delineate patient's space.
 - b. Orient patient to space.
 - c. If patient is immobilized, ask for instructions regarding placement of personal belongings.
 - d. If possible, allow patient to walk around the space and arrange personal belongings.

These measures enhance patient's potential

for regaining a sense of power.

3. Place call light, TV controls, bedside table, telephone, urinal, and other items within easy reach. Improve wherever possible to give control over use of these objects. Be attentive to patient's ability or inability to use hands and arms. *These measures help reduce patient's frustration over inability to reach items in immediate area.*

4. Reduce irritating noises, if possible, and explain reasons for alarms and other disturbances. *Excessive sensory stimuli can cause disorientation, hallucinations, and delusional thinking.*

5. Explain all treatments and procedures and encourage patient to participate in planning care. Provide choices for when and how activities will occur (bathing, eating, getting out of bed). *This increases patient's feeling of powerfulness and reduces passivity and dependence on caregiver.*

6. Provide as many situations as possible where patient can take control (positioning, choosing an injection site, visiting, etc.) *to help reduce potential for maladaptive coping behaviors.*

7. Encourage participation in self-care. Provide positive reinforcement for patient's activities *to encourage increasing participation in self-care in the future.*

8. Help patient learn as much about current health problem as possible. *The greater the understanding, the more the patient will feel in control.*

Documentation

- Patient's expressions of anger, frustration, sense of lack of control over the environment
- Patient's interest in surroundings, participation in self-care, verbalization of understanding, and demonstration of skill in relation to medical diagnosis
- Interventions to promote patient's control over the environment
- Patient's response to nursing interventions
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

Definition

Physical and emotional trauma that occurs as a result of sexual assault

Assessment

- History and circumstances of traumatic event
- Physical injuries sustained, including genitourinary, integumentary, musculoskeletal, neurologic
- Emotional reactions, including grief reaction, self-concept, spiritual distress
- Support systems available to the patient, including clergy, family or significant other, friends
- Problem-solving techniques usually employed by the patient

Defining characteristics

- Emotional reactions, including anger, embarrassment; fear of physical violence; humiliation, revenge, self-blame
- Multiple physical symptoms, including GI irritability, genitourinary discomfort, muscle tension, sleep pattern disturbances

Associated medical diagnoses (selected)

Incest, rape, spouse abuse

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient recovers from physical injuries. (1)
- Patient expresses feelings and fears. (2,3)
- Patient uses support systems. (3,4,5)

Interventions and rationales

1. Follow the medical regimen to manage physical injuries caused by the traumatic event. *This is first step in meeting patient's hierarchy of needs and depends on extent of patient's other injuries and intensity of psychological response.* ‡

2. Follow hospital protocol regarding legal responsibilities. *This requires knowledge of potential legal issues of rape and of role nurses may play as witnesses in legal proceedings.*

3. Provide emotional support:

- a. Be available to listen. *Active listening allows empathetic response to patient's feelings while being aware of own thoughts and behaviors.*
- b. Accept the patient's feelings, *to let the patient know her feelings are valid and acceptable.*
- c. Approach the patient in a warm, caring

manner, *to cultivate her trust and cooperation.*

d. Provide privacy during physical examination and interviewing process. *To protect patient's rights, no information should be released without prior consent.*

e. Assure patient of safety and take whatever measures are needed to ensure it. *This reduces patient's fears of repeated assault.*

4. Support the patient's family or significant other in their reactions to the traumatic event:

- a. Provide time for them to express their feelings and concerns.
- b. Help them understand the patient's reactions. *Giving them time to talk and providing accurate information helps them support their loved one.*

5. Offer referral to other support persons or groups, such as: clergy, crisis center, mental health professionals, rape counselors, Women Organized Against Rape. *This will help the patient express feelings and develop coping skills.*

Documentation

- Patient's expressions of feelings about self and traumatic event
- Physical findings and treatment
- Observations of family's interaction with patient
- Referrals to support persons
- Patient's response to nursing interventions
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Definition

Trauma syndrome that develops following rape or attempted rape in which the victim undergoes an acute phase of disorganization and a long-term reorganization. In a compound reaction, the patient experiences drastic changes in behavior, psychological equilibrium, and ability to function as a consequence of rape.

Assessment

- History and circumstances of traumatic event
- Physical symptoms reported by patient
- Physical injuries sustained, including genitourinary, integumentary, musculoskeletal, and neurologic
- Emotional reactions
- Behavioral and cognitive changes, such as expansive mood and affect, agitation, extreme alertness, and narrowed attention span
- Symptoms associated with posttrauma re-

sponse, including hypervigilance and a re-experience of assault

- Available support systems
- Past experience with physical or psychological trauma including coping strategies and problem-solving skills
- Occupation, educational background, life-style

Defining characteristics

- *Acute phase:* aggressive behavior, anger, embarrassment, fear of physical violence and death, homicidal ideation, humiliation, hysterical outbursts, revenge seeking, self-blame, suicidal ideation; multiple physical signs and symptoms (GI irritability, genitourinary discomfort, muscle tension, sleep-pattern disturbance); reactivated symptoms of previous conditions, such as physical illness, psychiatric illness; reliance on alcohol or drugs.
- *Long-term phase:* change in life-style, includ-

ing change of residence, seeking support from family and social network; repetitive nightmares

Associated medical diagnoses (selected)

Incest, rape, spouse abuse

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient recovers from physical injuries to the fullest extent possible. (1)
- Patient expresses feelings about the rape. (3,4)
- Patient reports feeling safe. (5)
- Patient takes first steps toward recovery from trauma. (6,7,8,9)
- Patient contacts appropriate support persons, or follow-up agency. (8,9)
- Patient reports a desire to reestablish and maintain interpersonal relationships. (8,9,10)

Interventions and rationales

1. Follow the medical regimen to manage physical injuries. *This is the first step in meeting the patient's needs.* ‡
2. Document and report rape or attempted rape to appropriate authorities *to help protect the patient's legal rights.*
3. When interviewing the patient, use open-ended questions and listen intently *to encourage the patient to express her feelings, both verbally and through behavior.*
4. Show the patient that you accept her feelings *to reassure the patient that her response*

to trauma is valid, but set limits on aggressive behavior to provide the patient with necessary structure.

5. Take appropriate measures to reassure the patient of her safety; for example:
 - a. Approach the patient carefully with open hands
 - b. Stay with the patient
 - c. Have female staff conduct the patient interview and physical examination.

Safety measures help to decrease patient's anxiety and reduce fears of another assault.

6. Direct the patient to perform purposeful activities, such as taking medications and following instructions of health care personnel.

Completing tasks helps to reduce patient's anxiety and restore her sense of control.

7. Educate the patient about the variety of responses to trauma. *The patient may feel that the extreme emotional turmoil she experiences following rape is abnormal. Learning that others have undergone the same experience may help decrease isolation.*

8. Provide the patient's family or significant other with an opportunity to express their reactions to the trauma and the patient's re-

sponse. Educate family members about compound reaction to rape *to help them support the patient.*

9. Refer the patient to appropriate support persons, such as clergy or rape counselor. Encourage the patient to participate in support groups or therapy groups offered by rape counseling center. *The patient may need long-term care to cope with the psychological consequences of rape.*

10. Provide ongoing support as the patient struggles to regain psychological equilibrium. Encourage her efforts to renew involvement in usual activities. *To achieve long-term personality reorganization, the patient will require time and consistent support.*

Documentation

- Patient's expressions of feelings related to trauma
- Observations of patient's behavior and interactions with others
- Nursing interventions
- Patient's response to interventions
- Referrals accepted by patient
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Definition

Trauma syndrome that develops following rape or attempted rape in which the victim undergoes an acute disorganization of her life-style and a long-term reorganization. In a silent reaction, the patient doesn't tell anyone about the rape or deal with her feelings about it.

Assessment

- Symptoms associated with posttrauma response
- Evidence of emotional distress, including shock, fear, anger, and guilt
- Behavioral and cognitive changes, such as lack of affect, agitation, decreased alertness, and narrowed attention span
- Evidence of physical injuries
- Available support systems
- Past experience with physical or psychological trauma including coping strategies and problem-solving skills

- Laboratory studies, including tests for pregnancy or sexually transmitted diseases

Defining characteristics

- Abrupt changes in relationships with men
- Increase in nightmares
- Increased anxiety during interview:
 - a. blocking of associations
 - b. minor stuttering
 - c. physical distress
- Pronounced changes in sexual behavior
- No expression that rape occurred
- Signs and symptoms of posttraumatic response, such as numbness, impaired concentration, disbelief, panic, extreme detachment, severe anxiety, anger, and depersonalization
- Sudden onset of phobic reactions

Associated medical diagnoses (selected)

Incest, rape, sexual assault, spouse abuse

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient discloses that sexual assault occurred. (1,2,3,4)
- Patient recovers from physical injuries to the fullest extent possible. (5)
- Patient makes contact with appropriate sources of support. (8)
- Patient expresses willingness to address psychosocial problems associated with traumatic experience. (5,6,7,8)

Interventions and rationales

1. Establish an atmosphere of trust *to help the patient overcome silence about rape.*
2. Confront the patient directly but gently with the question of whether she is a victim of rape or sexual assault. For example, you might say, "You seem very upset and you've told me about increased nightmares and a sudden loss of interest in sexual relations. These are common characteristics of victims of sexual assault. If you've been sexually assaulted, you can tell me. I'll help you." *The patient with a silent reaction needs patience and encouragement to overcome anxiety about disclosing rape.*

3. Clear up misconceptions the patient may have about the nature of rape and sexual assault. *If, for example, intercourse didn't take place or the attacker was a boyfriend, spouse, or family member, the patient may not believe that sexual assault occurred. Tell patient that sexual assault can take different forms and that all can be equally traumatic.*

4. If the patient remains unwilling to disclose the rape, tell her that you'll continue to be available to help. Encourage her to contact you if she feels the need *to provide a resource for future help and maintain communication.*

5. If the patient discloses rape, be careful to respond in a caring, nonjudgmental manner *to cultivate trust and cooperation.* Follow medical regimen to manage physical injuries (if rape was recent) and follow hospital protocol for documenting rape and reporting it to authorities *to ensure patient's physical well-being and protect her legal rights.* Use open-ended questions and listen intently *to encourage the patient to talk about the trauma.* If the patient is withdrawn, be patient when gathering infor-

mation *to allow the patient to proceed at her own pace.*

6. Emphasize to the patient that the attack was not her fault. *The patient with a silent reaction may feel intense guilt and shame over the assault.*

7. Educate the patient about the variety of emotional responses to trauma. Rape trauma syndrome is a variant of posttraumatic stress disorder. Responses such as suicidal ideation, disorientation, confusion, extreme detachment, nightmares, flashbacks, guilt, and depression are common. *The patient may believe that the emotional turmoil she experiences following rape is abnormal. Pointing out that others have undergone the same experience may lessen the patient's isolation, help her talk about her symptoms, and motivate her to seek follow-up care.*

8. Offer referral to appropriate support persons or groups, such as clergy, mental health professionals, or rape counselor. Contact a local rape crisis center for information about support group or therapy groups. Note that if only a single assault has occurred, short-term

(continued)

† Numbers following outcomes refer to interventions.

Interventions and rationales (continued)

counseling may be sufficient. However, if the patient is a survivor of several assaults or repeated incest, long-term psychotherapy may be required. *Appropriate referrals help ensure that the patient gets needed care.*

Documentation

- Evidence that patient has been raped, including patient's behavior, physical evidence of sexual assault
- Efforts made to help patient discuss rape and patient's response
- Nursing interventions
- Patient's response to interventions
- Referrals accepted by patient
- Evaluations for each expected outcome.

Care plan notes

Care plan notes

Relocation stress syndrome

related to inadequate preparation
for admission, transfer, or discharge

120

Definition

*Physiologic or psychosocial disturbances
caused by change in health care environment*

Assessment

- Reason for transfer or relocation
- Past experiences with relocation
- Nature of relocation
- Physical and mental status of patient, including health condition, cognitive function, functional abilities
- Financial resources
- Support systems, including family and friends, health care workers
- Resources available to help prepare for relocation
- Conditions in original environment versus conditions in new environment
- Coping and problem-solving abilities, including educational level, past experiences with relocation, participation in recreational activities or hobbies

Defining characteristics

- Anxiety
- Apprehension
- Change in eating patterns
- Dependency
- Depression
- Expressions of concern or anxiety about transfer
- Expressions of unwillingness to relocate
- Gastrointestinal disturbances
- Increased confusion (particularly among elderly patients)
- Increased verbalization of needs
- Insecurity
- Lack of trust
- Loneliness
- Restlessness
- Sad affect
- Sleep disturbance
- Unfavorable comparison of original and new staff or environment
- Vigilance

- Weight change
- Withdrawal

Associated medical diagnoses (selected)

Any change in physical, functional, or cognitive status that requires a change in the patient's environment, such as admission to the hospital, transfer from one unit or institution to another, or discharge.

Turn card over to find EXPECTED OUTCOMES,
INTERVENTIONS AND RATIONALES,
and DOCUMENTATION.

Expected outcomes †

- Patient requests information on new environment. (1,2,3,7)
- Patient communicates understanding of the relocation. (1,2,3,7)
- Patient and family members take steps to prepare for relocation. (2)
- Patient uses available resources. (4,5)
- Patient expresses satisfaction with adjustment to new environment. (2,3,4,5,6,7,8)

Interventions and rationales

1. Assign a primary nurse to the patient to *provide a consistent, caring, and accepting environment that enhances patient's adjustment and well-being.*
2. Help the patient and family prepare for relocation. Conduct group discussions, provide pictures of the new setting, and communicate any additional information that will ease the transition to *help the patient cope with new environment.*
3. If possible, allow patient and family to visit new location and provide introductions to new staff. *The more familiar the environment, the*

less stress the patient will experience during relocation.

4. Assess patient's needs for additional health care services before relocation to *ensure that patient receives appropriate care in new environment.*
5. Communicate all aspects of the patient's discharge plan to appropriate staff at the new location to *ensure continuity of care.*
6. Educate family members about relocation stress syndrome and its potential effects to *encourage family members to provide needed emotional support throughout the transition period.*
7. Encourage the patient to express emotions associated with relocation to *provide an opportunity to correct misconceptions, answer questions, and reduce anxiety.*
8. Reassure patient that family and friends know his new location and will continue to visit to *reduce feelings of abandonment and anxiety.*

Documentation

- Evidence of patient's emotional distress over relocation

- Patient's needs with regard to preparing for relocation
- Available resources and support systems
- Interventions to prepare patient and family for relocation and patient's and family's response
- Discharge plan instructions communicated to new staff
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

Relocation stress syndrome

related to inadequate preparation
for admission, transfer, or discharge

120

Definition

*Physiologic or psychosocial disturbances
caused by change in health care environment*

Assessment

- Reason for transfer or relocation
- Past experiences with relocation
- Nature of relocation
- Physical and mental status of patient, including health condition, cognitive function, functional abilities
- Financial resources
- Support systems, including family and friends, health care workers
- Resources available to help prepare for relocation
- Conditions in original environment versus conditions in new environment
- Coping and problem-solving abilities, including educational level, past experiences with relocation, participation in recreational activities or hobbies

Defining characteristics

- Anxiety
- Apprehension
- Change in eating patterns
- Dependency
- Depression
- Expressions of concern or anxiety about transfer
- Expressions of unwillingness to relocate
- Gastrointestinal disturbances
- Increased confusion (particularly among elderly patients)
- Increased verbalization of needs
- Insecurity
- Lack of trust
- Loneliness
- Restlessness
- Sad affect
- Sleep disturbance
- Unfavorable comparison of original and new staff or environment
- Vigilance

- Weight change
- Withdrawal

Associated medical diagnoses (selected)

Any change in physical, functional, or cognitive status that requires a change in the patient's environment, such as admission to the hospital, transfer from one unit or institution to another, or discharge.

Turn card over to find EXPECTED OUTCOMES,
INTERVENTIONS AND RATIONALES,
and DOCUMENTATION.

Expected outcomes †

- Patient requests information on new environment. (1,2,3,7)
- Patient communicates understanding of the relocation. (1,2,3,7)
- Patient and family members take steps to prepare for relocation. (2)
- Patient uses available resources. (4,5)
- Patient expresses satisfaction with adjustment to new environment. (2,3,4,5,6,7,8)

Interventions and rationales

1. Assign a primary nurse to the patient to *provide a consistent, caring, and accepting environment that enhances patient's adjustment and well-being.*
2. Help the patient and family prepare for relocation. Conduct group discussions, provide pictures of the new setting, and communicate any additional information that will ease the transition to *help the patient cope with new environment.*
3. If possible, allow patient and family to visit new location and provide introductions to new staff. *The more familiar the environment, the*

less stress the patient will experience during relocation.

4. Assess patient's needs for additional health care services before relocation to *ensure that patient receives appropriate care in new environment.*
5. Communicate all aspects of the patient's discharge plan to appropriate staff at the new location to *ensure continuity of care.*
6. Educate family members about relocation stress syndrome and its potential effects to *encourage family members to provide needed emotional support throughout the transition period.*
7. Encourage the patient to express emotions associated with relocation to *provide an opportunity to correct misconceptions, answer questions, and reduce anxiety.*
8. Reassure patient that family and friends know his new location and will continue to visit to *reduce feelings of abandonment and anxiety.*

Documentation

- Evidence of patient's emotional distress over relocation

- Patient's needs with regard to preparing for relocation
- Available resources and support systems
- Interventions to prepare patient and family for relocation and patient's and family's response
- Discharge plan instructions communicated to new staff
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

Role performance alteration related to ineffective coping

121a

Definition

Disruption in the ability to perform usual social, vocational, or family roles

Assessment

- Health history, including medical diagnosis, course and severity of illness, reason for hospitalization
- Patient's perception of illness and its effect on social and vocational roles
- Psychosocial status, including current stressors, support systems, hobbies, interests, work history, educational background, and changes in role function
- Family status, including roles of family members, effect of illness on patient's family, and family's understanding of patient's illness

Defining characteristics

- Change in perception of role (by self and others)
- Change in physical capacity to resume role
- Change in usual responsibilities
- Conflict among vocational, family, and social roles
- Denial of role or responsibility
- Lack of knowledge about roles and responsibilities

Associated medical diagnoses (selected)

This diagnosis may be associated with any illness that results in long-term disability or incapacitation. Examples include chronic obstructive pulmonary disease, coronary artery disease, dementias, personality disorders, quadriplegia, recurrent affective disorders, rheumatoid arthritis, schizophrenia, and substance abuse disorders.

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes [†]

- Patient expresses feelings about diminished capacity to perform usual roles. (1,2,3,5,12)
- Patient recognizes limitations imposed by illness and expresses feelings about these limitations. (1,2,3,4,5,12,13)
- Patient makes decisions regarding course of treatment and management of illness. (6,7,8,9,11,13,14)
- Patient continues to function in usual roles to as great a degree as possible. (9,10,13,14)

Interventions and rationales

1. If possible, assign the same nurse to the patient each shift *to establish rapport and foster development of a therapeutic relationship.*
2. Spend an ample amount of time with patient each shift *to foster sense of safety and decrease loneliness.*
3. Provide opportunities for patient to express thoughts and feelings *to help patient identify how altered role performance has affected his life.*
4. Convey belief in patient's ability to develop necessary coping skills. *By projecting a posi-*

tive attitude, you can help the patient gain confidence.

5. Be aware of patient's emotional vulnerability, and allow open expression of all emotions. *An accepting attitude will help the patient deal with the effects of chronic illness and loss of functioning.*
6. Provide opportunities for patient to make decisions, and encourage patient to maintain personal responsibilities. *Showing respect for the patient's decision-making ability enhances feelings of independence.*
7. Encourage the patient to participate in self-care activities, keeping in mind physical and emotional limitations. *Involvement in self-care promotes optimal functioning.*
8. Assess patient's knowledge of illness, and educate patient about condition, treatment, and prognosis. *Education will enable the patient to cope with the effects of illness more effectively.*
9. Encourage patient to be aware of personal strengths and to use them. *This will help maintain optimal functioning and foster a healthier self-perception.*
10. Encourage patient to continue to fulfill life

roles within constraints imposed by illness. *This will help patient maintain a sense of purpose and preserve connections with other people.*

11. Encourage patient to participate in care as an active member of health care team. *This will foster the establishment of mutually accepted goals between patient and caregivers. The patient who participates in care is more likely to take an active role in other aspects of life.*
12. Assist family members in identifying feelings about patient's decreased role functioning. Encourage participation in a support group. *Relatives of the patient may need social support, information, and an outlet for ventilating feelings.*
13. Offer patient and family a realistic assessment of patient's illness, and communicate hope for the immediate future. *Education helps promote patient safety and security and enables family members to plan for future health care requirements.*
14. Educate the patient and family about managing illness, controlling environmental factors

(continued)

[†] Numbers following outcomes refer to interventions.

Interventions and rationales (continued)

that affect the patient's health, and redefining roles to promote optimal functioning. *Through education, family members may become resources in the patient's care.*

Documentation

- Observations of the patient's physical, emotional, and mental status
- Patient's thoughts and feelings regarding illness and diminished role capacity
- Nursing interventions performed to help patient understand change in role functioning
- Patient's response to nursing interventions
- All health teaching, counseling, and precautions taken to maintain or enhance the patient's level of functioning
- Referrals to sources of support for patient and family
- Evaluations for each expected outcome.

Care plan notes

Care plan notes

Self-care deficit: Bathing and hygiene

related to musculoskeletal impairment

122

Definition

Inability to carry out activities associated with bathing and hygiene

Assessment

- History of injury or disease associated with musculoskeletal impairment
- Self-care abilities, including knowledge and use of adaptive equipment, preparation of equipment and supplies, technical or mechanical skills
- Musculoskeletal status, including coordination; functional ability; gait; mechanical restriction (cast, splint, traction); muscle tone, size, and strength; range of motion; tremors
- Psychosocial status, including coping mechanisms, family or significant other, life-style, patient's perceptions of health problem and self, personality

Defining characteristics

- Clinical evidence of musculoskeletal impairment
- Inability to carry out personal hygiene
- Inability to obtain or get to water source
- Inability to regulate water temperature or flow
- Inability to wash body or body parts

Associated medical diagnoses (selected)

Amyotrophic lateral sclerosis, brain or spinal cord tumor, cerebral palsy, cerebrovascular accident, fractures, Guillain-Barré syndrome, Huntington's disease, multiple sclerosis, multiple trauma, muscular dystrophy, myasthenia gravis (crisis), Parkinson's disease, rheumatoid arthritis, spinal cord injury, terminal cancer

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient's self-care needs are met. (1,2,4,5,6,7)
- Complications are avoided or minimized. (1,2,4,5,6,7,8)
- Patient communicates feelings about limitations. (3,8)
- Patient or significant other demonstrates correct use of assistive devices. (5)
- Patient or significant other carries out bathing and hygiene program daily. (4,5,6,7,8)

Interventions and rationales

1. Observe patient's functional level every shift; document and report any changes. *Careful observation guides adjustment of actions to meet patient's needs.*
2. Perform prescribed treatment for underlying musculoskeletal impairment. Monitor progress, reporting favorable and adverse responses to treatment. *Therapy must be consistently applied to aid patient's independence.*
3. Encourage patient to voice feelings and concerns about self-care deficits to *help patient achieve highest functional level possible.*
4. Monitor completion of bathing and hygiene

daily. Praise accomplishments. *Reinforcement and rewards may encourage renewed effort.*

5. Provide assistive devices, such as long handled toothbrush, for bathing and hygiene care; instruct on use. *Appropriate assistive devices encourage independence.*

6. Assist with or perform bathing and hygiene daily. Assist only when patient has difficulty to *promote feeling of independence.*

7. Instruct patient or significant other in bathing and hygiene techniques. Have patient or significant other demonstrate bathing and hygiene under supervision. Instructions to significant other can be given in writing. *Return demonstration identifies problem areas and increases significant other's self-confidence.*

8. Refer patient, as needed, to psychiatric liaison nurse, support group, or such community agencies as Visiting Nurses Association. *These extra resources will reinforce activities planned to meet patient's needs.*

Documentation

- Patient's expression of feelings and concerns about self-care limitations and their impact on body image and life-style

- Patient's willingness to participate in bathing and hygiene routine
- Observations of patient's impaired ability to perform self-care
- Patient's response to treatment for underlying condition
- Interventions to provide supportive care
- Patient's response to nursing interventions
- Instructions to patient or significant other, their understanding of instructions, and demonstrated skill in carrying out self-care functions
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

Self-care deficit: Bathing and hygiene

related to perceptual or cognitive impairment

123

Definition

Inability to carry out activities associated with bathing and hygiene

Assessment

- History of neurologic, sensory, or psychological impairment
- Age
- Self-care abilities, including knowledge and use of adaptive equipment, preparation of equipment and supplies, technical and mechanical skills
- Neurologic status, including cognition, communication ability, insight or judgment, level of consciousness, memory, motor ability, orientation, sensory ability
- Psychosocial status, including coping mechanisms, family or significant other, life-style, patient's perceptions of self, personality

Defining characteristics

- Clinical evidence of perceptual or cognitive impairment
- Impaired short-term or long-term memory
- Inability to carry out personal hygiene
- Inability to obtain or get to water source
- Inability to regulate water temperature or flow
- Inability to wash body or body parts

Associated medical diagnoses (selected)

Alcoholism, Alzheimer's disease, autism, bipolar disease (manic or depressive phase), brain tumor, cerebrovascular accident, head injury, Huntington's disease, Laënnec's cirrhosis, mental retardation, organic brain syndrome, psychoses

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient's self-care needs are met. (1,2,4,5,6,7,8,9,10,11)
- Complications are avoided or minimized. (1,2,4,5,8,9,10,11,12)
- Patient or significant other carries out self-care program daily. (4,5,6,7,8,9,10,11,12)
- Patient or significant other communicates feelings and concerns. (3,12)
- Patient or significant other identifies resources to help cope with problems after discharge. (12)

Interventions and rationales

1. Observe, document, and report patient's functional and perceptual or cognitive ability daily. *This allows adjustment of actions to meet patient's needs.*
2. Perform prescribed treatment for underlying condition. Monitor progress, and report favorable and adverse responses. *Therapy must be consistently applied to aid patient's independence.*
3. Allow patient to express frustration, anger, or feelings of inadequacy. Provide emotional

support to help patient achieve highest functional level.

4. Provide privacy to enhance patient's self-esteem.
5. Monitor completion of bathing and hygiene daily. Remind patient of what is to be accomplished. Offer praise. *Reinforcement and rewards may encourage daily activities.*
6. Allow ample time for patient to perform bathing and hygiene tasks. *Rushing creates unnecessary stress and promotes failure.*
7. Encourage patient to complete bathing and hygiene regimen. Provide positive, constructive feedback during task performance. *Reinforcement and rewards may encourage daily activities.*
8. Direct patient in bathing and hygiene measures, using simple instructions given one at a time, to aid comprehension.
9. Assist with bathing and hygiene daily only when patient has difficulty to encourage independence and self-reliance.
10. Give written instructions to significant other in bathing and hygiene techniques and supervise return demonstration. *Return demonstration identifies problem areas and in-*

creases significant other's self-confidence.

11. Discuss normal aspects of bathing. Reassure the patient with such statements as "You're in the tub," and "The water is only 3 inches deep," to guard against panic reaction caused by fear of being drowned.
12. Refer patient to psychiatric liaison nurse, support group, or community agency, as needed. *These extra resources will reinforce activities planned to meet patient needs.*

Documentation

- Patient's or significant other's expression of feelings and concern about self-care deficits
- Observations of patient's impaired ability to perform bathing and hygiene
- Patient's response to treatment for underlying condition
- Interventions to provide supportive care
- Instructions to patient (if capable) or significant other, their understanding of the instructions, and their demonstrated skill in carrying out self-care functions
- Patient's response to nursing interventions
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

Self-care deficit: Dressing and grooming related to musculoskeletal impairment

124

Definition

Impaired ability to perform activities associated with dressing and grooming

Assessment

- History of injury or disease associated with musculoskeletal impairment
- Self-care abilities, including knowledge and use of adaptive equipment, preparation of equipment and supplies, technical or mechanical skills
- Musculoskeletal status, including coordination; functional ability; gait; mechanical restriction (cast, splint, traction); muscle tone, size, and strength; range of motion; tremors
- Psychosocial status, including coping mechanisms, family or significant other, life-style, patient's perceptions of health problem and self, personality

Defining characteristics

- Clinical evidence of musculoskeletal impairment
- Impaired ability to fasten clothing
- Impaired ability to obtain or replace articles of clothing
- Impaired ability to put on or take off clothing
- Inability to maintain appearance at a satisfactory level

Associated medical diagnoses

Amyotrophic lateral sclerosis, brain or spinal cord tumor, cerebral palsy, cerebrovascular accident, fractures, Guillain-Barré syndrome, Huntington's disease, multiple sclerosis, multiple trauma, muscular dystrophy, myasthenia gravis (crisis), Parkinson's disease, rheumatoid arthritis, spinal cord injury, terminal cancer

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes†

- Patient's self-care needs are met. (1,2,4,5,6,7,8,9)
- Complications are avoided or minimized. (1,2,4,5,6,7,8,9,10)
- Patient communicates feelings about limitations. (3,10)
- Patient or significant other demonstrates correct use of assistive devices. (7)
- Patient or significant other carries out dressing and grooming program daily. (4,5,6,7,8,9,10)

Interventions and rationales

1. Observe patient's functional level every shift; document and report any changes. *This allows adjustment of actions to meet patient's needs.*
2. Perform prescribed treatment for underlying musculoskeletal impairment. Monitor progress, reporting favorable and adverse responses to treatment. *Therapy must be consistently applied to aid patient's independence.*
3. Encourage patient to voice feelings and concerns about self-care deficits *to help*

patient achieve highest functional level.

4. Provide enough time for patient to perform dressing and grooming tasks. *Rushing creates unnecessary stress and promotes failure.*
5. Monitor patient's abilities for dressing and grooming daily. *This identifies problem areas before they become a source of frustration.*
6. Encourage family to provide clothing easily managed by patient. Clothing slightly larger than regular size and Velcro straps may be helpful. *Such clothing makes independent dressing easier.*
7. Provide necessary assistive devices, such as long-handled shoe horn or zipper pull, as needed. Instruct on use. *Appropriate assistive devices encourage independence.*
8. Assist with or perform dressing and grooming; fasten clothes; comb hair; clean nails. Provide help only when patient has difficulty; *this promotes feeling of independence.*
9. Instruct patient or significant other in dressing and grooming techniques. Have patient or significant other demonstrate dressing and grooming techniques under supervision. Instructions to significant other can be given in

writing. *Return demonstration identifies problem areas and increases significant other's self-confidence.*

10. Refer patient, as needed, to psychiatric liaison nurse, support group, or such community agencies as Visiting Nurses Association. *These extra resources will reinforce activities planned to meet patient's needs.*

Documentation

- Patient's expression of feelings and concerns about self-care limitations and their impact on body image and life-style
- Patient's willingness to participate in dressing and grooming
- Observations of patient's impaired ability to perform dressing and grooming
- Interventions to provide supportive care
- Patient's response to nursing interventions
- Instructions to patient or significant other, their understanding of instructions, and demonstrated skill in carrying out self-care functions
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

Self-care deficit: Dressing and grooming

related to perceptual or cognitive impairment

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Definition

Inability to carry out activities associated with dressing and grooming

Assessment

- History of neurologic, sensory, or psychological impairment
- Age
- Self-care abilities, including knowledge and use of adaptive equipment, preparation of equipment and supplies, technical and mechanical skills
- Neurologic status, including cognition, communication ability, insight or judgment, level of consciousness, memory, motor ability, orientation, sensory ability
- Psychosocial status, including coping mechanisms, family or significant other, life-style, patient's perceptions of self, personality

Defining characteristics

- Clinical evidence of perceptual or cognitive impairment
- Impaired ability to fasten clothing
- Impaired ability to obtain or replace articles of clothing
- Impaired ability to put on or take off necessary items of clothing
- Impaired short-term or long-term memory
- Inability to maintain appearance at a satisfactory level

Associated medical diagnoses (selected)

Alcoholism, Alzheimer's disease, autism, bipolar disease (manic or depressive phase), brain tumor, cerebrovascular accident, head injury, Huntington's disease, Laënnec's cirrhosis, mental retardation, organic brain syndrome, psychoses

Expected outcomes †

- Patient's self-care needs are met. (1,2,4,5,6,7,8,9,10,11,12,13)
- Patient or significant other carries out self-care program daily. (4,5,6,7,8,9,10,11,12,13,14,)
- Patient or significant other communicates feelings and concerns. (3,14)
- Patient or significant other identifies resources to help cope with problems after discharge. (14)

Interventions and rationales

1. Observe, document, and report patient's functional and perceptual or cognitive ability daily. *Careful observation guides adjustment of nursing actions to meet patient's needs.*
2. Perform prescribed treatment for underlying condition. Monitor progress, and report favorable and adverse responses *to ensure consistent care.*
3. Allow patient to express frustration, anger, or feelings of inadequacy. Provide emotional support *to enhance coping.*
4. Provide privacy *to enhance patient's self-esteem.*

5. Monitor dressing and grooming daily *to identify problem areas.*
6. Provide assistive devices as needed *to encourage independence.*
7. Do not rush patient. *Rushing creates unnecessary stress and promotes failure.*
8. Remind patient of what is to be accomplished while performing actual task. Praise accomplishments *to foster self-confidence.*
9. Assist with dressing and grooming daily: fasten clothing; clean nails; comb hair. Select clothes and hand garments to patient one at a time in appropriate order. Provide help only when patient has difficulty *to promote a feeling of independence.*
10. Direct patient in grooming measures, using simple instructions given one at a time, *to aid comprehension.*
11. Encourage patient to complete dressing and grooming measures. Provide positive feedback during task performance. *Reinforcement and rewards may encourage effort.*
12. Encourage significant other to provide clothing easily managed by patient; clothing slightly larger than regular size and Velcro

straps may be helpful. *Such clothing makes independent dressing easier.*

13. Give written instructions to significant other in dressing and grooming technique, and supervise return demonstration *to identify problem areas and increase significant other's self-confidence.*

14. Refer patient, as needed, to psychiatric liaison nurse, support group, or such community agencies as Visiting Nurses Association. *These extra resources will reinforce activities planned to meet patient's needs.*

Documentation

- Patient's or significant other's expression of feelings and concern about self-care deficits
- Observations of patient's impaired ability to perform dressing and grooming activities
- Patient's response to underlying treatment
- Nursing interventions and patient's response
- Instructions to patient (if capable) or significant other, their understanding of the instructions, and their demonstrated skill in carrying out self-care functions
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

Definition

Inability to carry out the self-care activity: feeding

Assessment

- History of injury or disease associated with musculoskeletal impairment
- Self-care abilities, including knowledge and use of adaptive equipment, preparation of equipment and supplies, technical and mechanical skills
- Musculoskeletal status, including coordination, functional ability, gait; mechanical restriction (cast, splint, traction); muscle tone, size and strength; range of motion; tremors
- Psychosocial status, including coping mechanisms, family or significant other, life-style, motivation, patient's perception of health problem and of self, personality

Defining characteristics

- Self-feeding deficit; inability to bring food from receptacle to mouth
- Clinical evidence of musculoskeletal impairment

Associated medical diagnoses (selected)

Amyotrophic lateral sclerosis, brain or spinal cord tumor, cerebral palsy, cerebrovascular accident, fractures, Guillain-Barré syndrome, Huntington's disease, multiple sclerosis, multiple trauma, muscular dystrophy, myasthenia gravis (crisis), Parkinson's disease, rheumatoid arthritis, spinal cord injury, terminal cancer

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient expresses feelings about feeding limitations. (5)
- Patient maintains weight at _____ lb. (3)
- Patient has no evidence of aspiration. (4)
- Patient consumes _____% of diet. (1,2,6)
- Patient or significant other demonstrates correct use of assistive devices. (6,7)
- Patient or significant other carries out feeding program daily. (6,7,8)

Interventions and rationales

1. Observe patient's functional level every shift; document and report any changes. *This allows adjustment to patient's needs.*
2. Perform prescribed treatment for underlying musculoskeletal impairment. Monitor progress and report responses. *Therapy must be applied consistently to facilitate independence. ‡*
3. Weigh patient weekly and record. Report change of more than 1 lb per week, *to ensure adequate nutrition and fluid balance.*
4. Monitor and record breath sounds every 4 hours, *to check for aspiration of food.* Report crackles, wheezes, or rhonchi.
5. Encourage patient to ventilate feelings and

concerns about feeding deficits, *to help patient achieve highest functional level.*

6. Initiate feeding program:

- a. Determine types of food best handled by patient. *Easily handled foods encourage patient's feelings of independence.*
- b. Place patient in high Fowler's position *to aid swallowing and digestion.* Support weakened extremities, wash patient's face and hands before meals.
- c. Provide assistive devices; instruct patient on use *to allow more independence.*
- d. Supervise or assist at each meal; for example, cut food into small pieces. *This aids chewing, swallowing, and digestion and reduces risk of choking or aspiration.*
- e. Feed patient slowly. *Rushing causes stress in patient, reducing digestive activity and causing intestinal spasms.*
- f. Keep suction equipment at bedside *to remove aspirated foods if necessary.*
- g. Instruct patient or significant other in feeding techniques and equipment. *This aids understanding and encourages compliance.*

h. Record percentage of food consumed, *to ensure adequate nutrition.*

7. Encourage patient to carry out aspects of feeding according to abilities. *This gives patient sense of achievement and control.*

8. Refer patient to psychiatric liaison nurse, support group, or such community agencies as Visiting Nurse Association and Meals on Wheels. *Additional resources reinforce activities planned to meet patient's needs.*

Documentation

- Patient's expression of feelings and concern about inability to feed self
- Observations of patient's impaired ability to perform self-care
- Patient's response to treatment
- Patient's weight
- Patient's intake
- Interventions to provide supportive care
- Instructions to patient and significant other, understanding of instructions, and demonstrated skill in carrying out self-care functions
- Patient's response to interventions
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Definition

Inability to feed self

Assessment

- History of neurologic, sensory, or psychological impairment
- Age
- Self-care abilities, including knowledge and use of adaptive equipment, preparation of equipment and supplies, technical and mechanical skills
- Neurologic status, including cognition, communication ability, insight or judgment, level of consciousness, memory, motor ability, orientation, sensory ability
- Psychosocial status, including coping mechanisms, family or significant other, life-style, patient's perceptions of self, personality

Defining characteristics

- Clinical evidence of perceptual or cognitive impairment
- Impaired short-term or long-term memory
- Inability to bring food from receptacle to mouth

Associated medical diagnoses (selected)

Alcoholism, Alzheimer's disease, autism, bipolar disease (manic or depressive phase), brain tumor, cerebrovascular accident, head injury, Huntington's disease, Laënnec's cirrhosis, mental retardation, organic brain syndrome, psychoses

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient's self-care needs are met. (1,3,5,6,7,8,9,10,11,12)
- Patient maintains weight. (2)
- Patient or significant other carries out feeding program daily. (5,6,7,8,9,10,11,12,13)
- Patient or significant other communicates feelings and concerns. (4,13)
- Patient or significant other identifies resources to help cope with problems after discharge. (13)

Interventions and rationales

1. Observe, document, and report patient's functional and perceptual or cognitive ability daily. *Careful observation guides adjustment of actions to meet patient's needs.*
 2. Weigh patient weekly and record results. Report loss of 2 lbs or more *to ensure adequate nutrition and fluid balance.*
 3. Perform prescribed treatment for underlying condition. Monitor progress, and report favorable and adverse responses. *Therapy must be consistently applied to aid patient's independence.*
 4. Allow patient to express frustration, anger,
- or feelings of inadequacy. Provide emotional support *to help patient come to terms with self-care deficit and achieve highest functional level.*
 5. Determine types of food best handled by patient; for example, finger foods, soft or liquid diet. *Easily handled foods encourage patient's feelings of independence.*
 6. Provide assistive devices at each meal, as needed. *These allow patient to do as much as possible for self.*
 7. Place patient in high Fowler's position *to reduce swallowing difficulty and aid digestion.*
 8. Supervise or assist at each meal; for example, cut food into small pieces *to assist chewing, swallowing, and digestion, and reduce risk of choking or aspiration.*
 9. Feed patient slowly. Do not rush. *Rushing causes stress in patient, reducing digestive activity and causing intestinal spasms.*
 10. Encourage patient to do as much for self as possible, using simple instructions given one at a time, *to aid comprehension.*
 11. Keep suction equipment at bedside *to remove aspirated foods if necessary.*
 12. Instruct patient or significant other in feed-

ing techniques and use of equipment. Have patient or significant other give return demonstration of feeding and equipment use under supervision. *This aids understanding and encourages compliance.*

13. Refer patient, as needed, to psychiatric liaison nurse, support group, or such community agencies as Visiting Nurses Association. *These extra resources will reinforce activities planned to meet patient's needs.*

Documentation

- Patient's or significant other's expression of feelings and concern about difficulty with feeding
- Observations of patient's impaired ability to feed self
- Weight
- Patient's response to treatment
- Interventions to provide supportive care
- Instructions to patient (if capable) or significant other, their understanding of the instructions, and their demonstrated skill in carrying out instructions
- Patient's response to nursing interventions
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

Definition

Inability to carry out toileting routine

Assessment

- History of injury or disease associated with musculoskeletal impairment
- Self-care abilities, including knowledge and use of adaptive equipment, preparation of equipment and supplies, technical or mechanical skills
- Musculoskeletal status, including coordination; functional ability; gait; mechanical restriction (cast, splint, traction); muscle tone, size, and strength; range of motion; tremors
- Psychosocial status, including coping mechanisms, family or significant other, life-style, patient's perceptions of health problem and self, personality

Defining characteristics

- Clinical evidence of musculoskeletal impairment
- Inability to carry out proper toilet hygiene
- Inability to flush toilet or empty commode
- Inability to get to toilet or commode
- Inability to manipulate clothing for toileting
- Inability to sit on or rise from toilet or commode

Associated medical diagnoses (selected)

Amyotrophic lateral sclerosis, brain or spinal cord tumor, cerebral palsy, cerebrovascular accident, fractures, Guillain-Barré syndrome, Huntington's disease, multiple sclerosis, multiple trauma, muscular dystrophy, myasthenia gravis (crisis), Parkinson's disease, rheumatoid arthritis, spinal cord injury, terminal cancer

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient's self-care needs are met. (1,2,4,5,6,7,8)
- Complications are avoided or minimized. (1,2,4,5,6,7,8,9)
- Patient communicates feelings about limitations. (3,9)
- Patient maintains continence. (5,6,7)
- Patient or significant other demonstrates correct use of assistive devices. (5)
- Patient or significant other carries out toileting program daily. (4,5,6,7,8,9)

Interventions and rationales

1. Observe patient's functional level every shift; document and report any changes. *Careful observation guides adjustment of interventions to meet patient's needs.*
2. Perform prescribed treatment for underlying musculoskeletal impairment. Monitor progress, reporting favorable and adverse responses to treatment. *Therapy must be consistently applied to aid patient's independence.*
3. Encourage patient to voice feelings and concerns about self-care deficits to help patient achieve highest functional level possible.

4. Monitor intake and output and skin condition; record episodes of incontinence. *Accurate intake and output records can identify potential imbalances.*
5. Use assistive devices as needed, such as external catheter at night, bedpan or urinal every 2 hours during day, and adaptive equipment for bowel care. Instruct on use. As control improves, reduce use of assistive devices. *Assisting at appropriate level helps maintain patient's self-esteem.*
6. Assist with toileting if needed. Allow patient to perform independently as much as possible to foster patient's self-confidence.
7. Perform urinary and bowel care if needed. Follow urinary or bowel elimination plans. *Monitoring success or failure of toileting plans helps identify and resolve problem areas.*
8. Instruct patient or significant other in toileting routine. Instructions to significant other can be given in writing. Have patient or significant other demonstrate toileting routine under supervision. *Return demonstration identifies problem areas and increases significant other's self-confidence.*
9. Refer patient, as needed, to psychiatric liai-

son nurse, support group, or such community agencies as Visiting Nurses Association. *These extra resources will reinforce activities planned to meet patient's needs.*

Documentation

- Patient's expression of feelings and concerns about self-care limitations and their impact on body image and life-style
- Patient's willingness to participate in self-care
- Intake and output
- Observations of patient's impaired ability to perform toileting routine and patient's response to treatment
- Interventions to provide supportive care
- Instructions to patient or significant other, their understanding of instructions, and demonstrated skill in carrying out self-care functions
- Patient's response to nursing interventions
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

Definition

Inability to carry out toileting routine

Assessment

- History of neurologic, sensory, or psychological impairment
- Age
- Self-care abilities, including knowledge and use of adaptive equipment, preparation of equipment and supplies, technical or mechanical skills
- Neurologic status, including cognition, communication ability, insight or judgment, level of consciousness, memory, motor ability, orientation, sensory ability
- Psychosocial status, including coping mechanisms, family or significant other, life-style, patient's perceptions of self, personality

Defining characteristics

- Clinical evidence of perceptual or cognitive impairment
- Impaired short-term or long-term memory
- Inability to carry out proper toilet hygiene
- Inability to flush toilet or empty commode
- Inability to get to toilet or commode
- Inability to manipulate clothing for toileting
- Inability to sit on or rise from toilet or commode

Associated medical diagnoses (selected)

Alcoholism, Alzheimer's disease, autism, bipolar disease (manic or depressive phase), brain tumor, cerebrovascular accident, head injury, Huntington's disease, Laënnec's cirrhosis, mental retardation, organic brain syndrome, psychoses

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes†

- Patient's self-care needs are met. (1,2,4,5,6,7,8,9,10,11)
- Complications are avoided or minimized. (1,2,4,5,6,9,10,11,12)
- Patient or significant other carries out toileting program daily. (4,5,6,7,8,9,10,11,12)
- Patient maintains continence. (5,6,7)
- Patient or significant other communicates feelings and concerns. (3,12)
- Patient or significant other identifies resources to help cope with problems and with discharge from hospital. (12)

Interventions and rationales

1. Observe, document, and report patient's functional and perceptual or cognitive ability daily. *This allows adjustment of actions to meet patient's needs.*
2. Perform prescribed treatment for underlying condition. Monitor progress, and report favorable and adverse responses *to guide therapy.*
3. Allow patient to express frustration, anger, or feelings of inadequacy. Provide emotional support *to help patient achieve highest functional level.*

4. Monitor intake and output; record episodes of incontinence. *Accurate intake and output records can identify potential imbalances.*
5. Use assistive devices, such as external catheter at night, bedpan or urinal every 2 hours during day, and adaptive equipment for bowel care. As control improves, reduce use of assistive devices. *Assisting at appropriate level enhances patient's self-esteem.*
6. Assist with toileting, if needed, using visual and auditory cues to stimulate urination. *This allows patient to perform independently as much as possible.*
7. Allow ample time for patient to perform toileting routine. *Rushing creates unnecessary stress and promotes failure.*
8. Provide positive, constructive feedback when assisting with toileting. *Reinforcement and rewards may enhance self-esteem.*
9. When assisting with toileting, use simple instructions given one at a time *to aid comprehension.*
10. Complete urinary and bowel care if patient is unable to do so. Follow urinary and bowel elimination plans. *Monitoring success or failure of toileting plans helps identify and resolve*

problem areas.

11. Give written instructions in toileting routine to significant other and supervise return demonstration. *Return demonstration identifies problem areas and increases significant other's self-confidence.*
12. Refer patient to psychiatric liaison nurse, support group, or community agency, as needed. *These extra resources will reinforce activities planned to meet patient's needs.*

Documentation

- Patient's or significant other's expression of feelings and concern about self-care deficits
- Observations of patient's impaired ability to perform toileting routine
- Patient's response to treatment for underlying condition
- Interventions to provide supportive care
- Intake and output
- Instructions to patient (if capable) or significant other, their understanding of the instructions, and their demonstrated skill in carrying out self-care functions
- Patient's response to nursing interventions
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

Definition

Long-standing negative self-evaluation or feelings about self or capabilities

Assessment

- Reason for hospitalization or outpatient treatment
- Age
- Sex
- Developmental stage
- Family system, including: marital status, role in the family, sibling position
- Perception of health problem
- Past experience with health care system
- Mental status, including abstract thinking, affect, communication, general appearance, judgment or insight, memory, mood, orientation, perception, thinking process
- Belief system, including norms, religion, values
- Social interaction pattern
- Social and occupational history

- Perception of self (past and present), including body image, coping mechanisms, problem-solving ability, self-worth
- Past experience with crisis
- Past history of treatment for psychosocial disturbance, including hospitalization, medication, psychotherapy, suicidal ideation, plans, past attempts
- Neurovegetative signs, including ability to experience pleasure, appetite, energy level, sleep

Defining characteristics

- Patient evaluates self as unable to deal with events
- Patient exhibits nonassertive or passive tendency
- Patient expresses shame or guilt
- Patient has difficulty making decisions
- Patient hesitates to try new things or situations
- Patient overly conforms to or depends on

others' opinions

- Patient seeks excessive reassurance
- Patient voices self-negating thoughts

Associated medical diagnoses (selected)

Medical diagnoses include cardiovascular disease, chronic illnesses requiring lifelong treatment (such as hemophilia, chronic obstructive pulmonary disease, Crohn's disease, diabetes mellitus, end-stage renal disease, seizure disorders), endocrine or metabolic disorders, neurologic or neuromuscular disease, and any illness or injury resulting in chronic pain, permanent disability, or disfigurement. *Psychiatric diagnoses* include anxiety, bipolar disorder, depression, panic state, self-destructive behaviors (anorexia nervosa, bulimia, substance abuse, attempts at suicide), personality disorders (borderline, dependent, obsessive-compulsive, passive-dependent)

Expected outcomes †

- Patient voices feelings related to self-esteem. (1,2,3,4,12)
- Patient reports feeling safe in hospital environment. (2,4)
- Patient makes verbal contract not to harm self while in hospital. (4,5)
- Patient joins gradually in self-care and decision making process. (6,7,8)
- Patient engages in social interaction with others. (9)
- Patient demonstrates verbally and behaviorally a decrease in negative self-evaluation. (8,9,10)
- Patient voices acceptance of positive and negative feedback without exaggeration. (1,2,10)

Interventions and rationales

1. Provide for a specific amount of uninterrupted non-care-related time to engage patient in conversation. *This gives patient time for self-exploration.*
2. Listen to patient with understanding, responding with nonjudgmental acceptance, genuine interest, and sincerity. *This expands*

patient's self-awareness and reduces element of threat.

3. Assess patient's mental status through interview and observation at least once weekly. *High anxiety from self-rejection may cause cognitive, sensory, or perceptual disturbances.*
4. Assess suicide risk and lethal potential, as indicated. *Extremely low levels of self-esteem may lead to suicide.*
5. Institute suicidal precautions according to protocol. *Patient's behavior must be supervised until self-control is adequate for safety.*
6. Provide patient with simple, structured daily routine. *Structured activity sets limits to patient's anxious behaviors.*
7. Encourage patient to care for self to the extent possible. *Patient may neglect or reject aspects of self-care, from feelings of self-hate.*
8. Involve patient in decisions about care on a gradual basis, *to reduce feelings of ambivalence, procrastination and lack of confidence in decision making.*
9. Arrange situations to encourage social interaction between patient and others. *Disturbed interpersonal relationships are a direct expression of self-hate.*

10. Provide patient with positive feedback for verbal reports and behaviors indicative of improved self-esteem. *This encourages future adaptive coping behaviors.*

11. Help patient mobilize resources for assistance when discharged, *to help patient replace maladaptive coping behaviors with more adaptive ones.*

12. Refer patient to mental health professional as indicated. *Severity of symptoms accompanying chronic low self-esteem may require long-term psychotherapy. ‡*

Documentation

- Patient's verbal expressions and behaviors indicative of low self-esteem
- Mental status examination (baseline and ongoing)
- Suicide assessment, interventions, and patient's response
- All nursing interventions implemented to facilitate improved self-esteem
- Patient's response to interventions
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Definition

Negative self-evaluation or feelings about self that develop in response to a loss or change in an individual who previously had a positive self-evaluation

Assessment

- Age
- Sex
- Developmental stage
- Family system, including marital status, role in family, sibling position
- Reason for hospitalization
- Mental status, including affect, general appearance, mood
- Cognitive ability
- Behavior
- Past perception of self
- Current perception of self

Defining characteristics

- Difficulty making decisions
- Episodic occurrence of negative self-appraisal in response to life events in a person with a previously positive self-evaluation
- Evaluation of self as unable to handle situational events
- Verbalization of negative feelings about self (helplessness, uselessness)

Associated medical diagnoses (selected)

This nursing diagnosis can be used with any patient experiencing an anticipated or actual loss (body part, normal body function, control over environment, threat to life). Examples include carcinoma; cerebrovascular accident; communicable diseases; conditions requiring amputation, hysterectomy, mastectomy, or osotomy; immunosuppressive conditions; myocardial infarction; or any injury or illness resulting in prolonged hospitalization

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient voices feelings related to current situation and its effect on self-esteem. (1,2)
- Patient verbally describes appraisal of self before current health problem. (1,2)
- Patient participates in decisions related to care and therapies. (1,2,3,4)
- Patient reports a sense of control over life events. (2,4,5)
- Patient articulates a return to previous positive feelings about self. (2,3,5)

Interventions and rationales

1. Encourage patient to express feelings about self (past and present). *Self-exploration encourages patient to consider future change.*
2. Provide for a specific amount of uninterrupted non-care-related time to engage patient in conversation. *Mutuality helps patient assume ultimate responsibility for coping responses.*
3. Assess patient's mental status through interview and observation at least once daily. *If anxiety resulting from self-rejection becomes severe, patient may experience disorientation, psychotic symptoms.*

4. Involve patient in decision making process. *Expressions of low self-esteem include ambivalence and procrastination.*
5. Provide patient with positive feedback for verbal reports or behaviors indicative of a return to positive self-appraisal. *This gives patient feelings of significance, approval and competence to cope effectively with stressful situations.*

Documentation

- Patient's expressions of lowered self-esteem
- Mental status assessment (baseline and ongoing)
- Nursing interventions directed toward a return to previous positive self-esteem
- Patient's response to interventions
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

Definition

Negative self-evaluation or feelings about self or self capabilities that may be directly or indirectly expressed

Assessment

- Age
- Developmental stage
- Sex
- Family system, including: marital status, sibling position
- Reason for hospitalization or outpatient treatment
- Patient's perception of health problem
- Past experience with health problems
- Mental status, including affect, behavior, cognitive ability, general appearance, mood
- Usual coping behaviors during stress
- Social interaction pattern

Defining characteristics

- Patient becomes hypersensitive to slight or criticism
- Patient denies problems evident to others
- Patient evaluates self as unable to deal with events
- Patient exhibits grandiosity
- Patient expresses shame or guilt
- Patient hesitates to try new things or situations
- Patient projects blame or responsibility for problems
- Patient rationalizes away or rejects positive feedback and exaggerates negative feedback about self
- Patient rationalizes personal failures
- Patient voices self-negating thoughts

Associated medical diagnoses (selected)

Self-esteem is an essential issue affecting all hospitalized clients. Examples include the following physical and emotional conditions: amputation, anxiety, burns, communicable diseases, congenital anomalies, depression, immunosuppressive conditions, infertility, mastectomy, menopause or hysterectomy, narcissistic or borderline personality disorder, ostomy, sexual dysfunction, substance abuse

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient voices feelings related to self-esteem. (1,2,3)
- Patient participates in decisions related to care and therapies. (2,4,7)
- Patient engages in social interaction with others. (5)
- Patient voices an acceptance of positive or negative feedback without exaggeration. (2,6)
- Patient initiates action to attain higher level of wellness, physically and emotionally. (4,6)
- Patient articulates at least two positive qualities about self. (1,2,6)

Interventions and rationales

1. Encourage patient to express feelings about self. *Active listening is the most basic therapeutic skill.*
2. Allow a specific amount of uninterrupted, non-care-related time to engage patient in conversation. *This creates environment that encourages patient to ventilate feelings at own pace.*
3. Assess patient's mental status through interview and observation at least once daily.

This helps detect abnormal feelings and behaviors.

4. Involve patient in decision making process, *to reduce patient's feelings of dependence on others.*

5. Arrange situations to encourage social interaction between patient and others. *Improving social environment helps restore confidence and self-esteem.*

6. Provide patient with positive feedback for verbal reports or behaviors indicating improved self-esteem. *This encourages future effective coping behaviors.*

7. Refer patient to mental health professional if indicated. *Consultation can ease frustration, increase objectivity and foster collaborative approach to patient's care.*

Documentation

- Patient's expressions of lowered self-esteem
- Mental status assessment (baseline and ongoing)
- Interventions directed toward improved self-esteem
- Patient's response to nursing interventions
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

Definition

State in which an individual is at risk of performing a deliberate act of self-harm that's intended to produce immediate tissue damage

Assessment

- Age
- Sex
- Developmental history
- Current stress level and coping behaviors
- Mental status, including judgment, thought content, and mood
- Family history, including abusive behavior
- Previous episodes of self-mutilation or suicide attempts
- Substance abuse history
- Social history, including sexual activity and aggression within peer group

Risk factors

- Lability of affect
- Borderline personality disorder (especially in females 16 to 25 years of age)
- Childhood emotional disturbances or abuse
- Command hallucinations
- Dissociative episodes
- Emotional deprivation by parents
- Expressions of self-hatred
- Feelings of depression or emptiness
- History of dysfunctional family upbringing
- History of physical or sexual abuse
- Inability to cope with increased stress
- Lack of sensory stimuli
- Low self-esteem
- Psychotic state (especially in young males)

Associated medical diagnoses (selected)

Autism, borderline personality disorder, developmental disability, factitious disorder with physical symptoms, malingering, multiple personality disorder, sexual masochism

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes [†]

- Patient doesn't harm himself while in the hospital. (2,3,4,6,7,8,10,11)
- Patient expresses increased sense of security. (1,2,3,6,7,8)
- Patient reports being able to cope better with disorganization, aggressive impulses, anxiety, or hallucinations. (5,6)
- Patient no longer experiences dissociative states or experiences fewer of them. (5)
- Patient participates in therapeutic milieu. (8,12)
- Patient reports suicidal thoughts to staff. (11)

Interventions and rationales

1. Limit the number of staff members interacting with the patient *to provide continuity of care and enhance sense of security.*
2. Have staff make frequent, short contacts with patient *to reassure patient without stifling independence.*
3. Remove all dangerous objects from the patient's environment *to promote safety.*
4. Make short-term verbal "contracts" with the patient stating that the patient won't harm himself *to make patient aware that he is ultimately*

responsible for his own safety, and that he is capable of guaranteeing it.

5. Administer psychotropic medications, as ordered *to reduce tension, impulsive behavior, hallucinations, and panic.*

6. If the patient enters a dissociative state or hallucinates, move him to a quiet room with reduced stimuli. If restraints must be used, remain with the patient and provide reassurance *to calm patient and orient him to reality.* [‡]

7. As ordered, place patient under observation *to provide protection and increase patient's sense of security.* If hospitalized, the patient can be "zoned," or asked to remain in areas within sight of staff. [‡]

8. If patient is participating in therapeutic milieu, discuss patient's risk of self-harm with community members *to provide enhanced protection and psychological support.*

9. If the patient harms himself, care for the injuries in a calm, nonjudgmental manner. Encourage the patient to talk about the feelings that prompted the self-mutilation. *Discussion may help the patient connect self-destructive behavior to the feelings that preceded it. Discussion may also provide an opportunity to*

explore alternative ways of dealing with negative thoughts and feelings.

10. If self-destructive acts persist, consider developing a behavior-modification program, where periods of self-control are rewarded through benefits such as personal attention or material items *to reinforce self-control.*

11. Ask patient directly if he is thinking of suicide and, if so, what plan he has. *A self-destructive patient may become suicidal and, therefore, require additional precautions.*

12. Hold frequent treatment team meetings *to ensure consistent care that is appropriate to patient's current behavior.*

Documentation

- Nursing interventions performed and patient's response
- Contracts between patient and nurse
- Patient's responses to medication and behavioral modification program
- Revisions to treatment plan
- If necessary, a "bodygram" to document self-inflicted injuries
- Evidence of suicidal ideation
- Evaluations for each expected outcome.

[†] Numbers following outcomes refer to interventions.

[‡] Indicates doctor-ordered instruction.

Sensory or perceptual alteration (auditory)

related to altered sensory
reception, transmission, or integration

134

Definition

Change in the characteristics of auditory stimuli

Assessment

- History of ear disorders, trauma, surgery
- Age
- Auditory status, including ear position, size, and symmetry; skin color and texture; tympanic membrane (cerumen, color of canal, deformities, discharge, intactness or tension, landmarks); use of hearing aid
- Rinne test
- Weber's test
- Communication status, including adaptive responses (gestures, lipreading, signing), level of comprehension and expression, speech pattern
- Environmental factors; for example, factory noise
- Activities of daily living
- Behavioral assessment, including coping

mechanisms, willingness to cooperate with treatment

Defining characteristics

- Altered conceptualization
- Altered communication pattern, reduced facial expression
- Anger
- Apathy or passiveness
- Auditory distortion
- Change in behavior pattern, decreased social interaction
- Change in response to auditory stimuli
- Clinical evidence of impaired (decreased) hearing ability
- Depression
- Disorientation
- Hallucinations
- Reported or measured change in auditory activity
- Restlessness

Associated medical diagnoses (selected)

Acoustic neuroma, auditory nerve damage, chronic suppurative otitis media, deafness (uncompensated), drug-induced deafness, otosclerosis, presbycusis

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient discusses impact of auditory loss on life-style. (1,2)
- Patient maintains orientation to person, place, and time. (3,4,5)
- Patient expresses feeling of comfort and security. (3,6,7)
- Patient shows interest in external environment. (4,5)
- Patient compensates for auditory loss by use of signing, gestures, lipreading, hearing aid, etc. (2,8)
- Patient plans to use community resources to assist with auditory deficit. (9)

Interventions and rationales

1. Allow patient to express feelings about hearing loss. Convey a willingness to listen, but do not pressure patient to talk. *Giving patient chance to talk about hearing loss enhances acceptance of loss.*
2. Determine how to communicate effectively with client, using gestures, written words, signing, lipreading. If patient has a hearing aid, encourage its use. *Planned communication with patient improves care delivery.*

3. Give patient clear, concise explanations of treatments, procedures, etc. Avoid information overload. Face patient when speaking; enunciate words clearly, slowly, and in normal speaking voice; avoid putting hands to mouth when speaking. Wearing red lipstick helps to define the mouth. *Patient will be better able to join in care with better understanding of treatment plan.*

4. Provide sensory stimulation by using tactile and visual stimuli to help compensate for hearing loss. Encourage family to bring familiar objects from home. *Sensory stimulation of patient's other senses helps compensate for hearing loss.*

5. Provide reality orientation if patient is confused or disoriented to *permit more effective patient-staff interaction.*

6. Make sure other staff members are aware of patient's hearing deficit. Record information on patient's Kardex and chart cover. *This ensures effective nursing care delivery by staff.*

7. Respond to call light by going to patient's room as soon as possible. If feasible, assign same staff members to care for patient. *These measures reduce patient's fears.*

8. Educate patient in alternative ways of coping with hearing loss; care of hearing aid, if prescribed; and safety and protective measures to avoid harm or injury (use of amplifier or signal devices on telephone, visual cues in environment, etc.). *Knowledgeable patient will be better able to cope with hearing loss.*

9. Refer to appropriate community resources, such as American Organization for the Education of the Hearing Impaired, to help patient adapt to loss. Involve family or significant other in planning and encourage participation. *These measures help patient and family cope better with hearing loss.*

Documentation

- Patient's statement of feelings about auditory loss
- Observations of patient's behavior or response to auditory loss and use of adaptive aids
- Instructions regarding safety and protective measures and patient's intent to use appropriate resources
- Patient's response to nursing interventions
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

Definition

Change in the sense of taste

Assessment

- Taste sensation, including change from baseline, ability to differentiate sweet, salty, sour, and bitter taste
- Health history, including trauma, infection, vitamin or mineral deficiency, neurologic or oral disorders, chemotherapy or radiation therapy
- Medication history, including use of certain antidepressants (such as clomipramine), antineoplastic agents, penicillamine, captopril, lithium, interferon alfa 2a, levamisole, zidovudine
- Evidence of loss of appetite
- Weight change from baseline
- Mouth dryness
- Smoking history
- Sense of smell

Defining characteristics

- Altered taste sense
 - a. Complete loss of taste (ageusia)
 - b. Distorted sense of taste (dysgeusia)
 - c. Food tastes unpleasant or revolting (cageusia)
 - d. Partial loss of taste (hypogeusia)
- Loss of appetite
- Weight loss

Associated medical diagnoses (selected)

Brain stem lesions, chemotherapy, radiation therapy, basilar skull fracture, Bell's palsy, common cold, influenza, oral cancer, Sjögren's syndrome, thalamic syndromes, viral hepatitis (acute), vitamin B₁₂ deficiency, zinc deficiency

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient reports changes in sense of taste. (1,2)
- Patient identifies ways to enhance enjoyment of food. (4,5)
- Patient consumes ____ % of diet. (4,5)
- Patient maintains weight. (3,4,5)

Interventions and rationales

1. Assess changes in sense of taste *to establish a baseline.*

- a. Gently withdraw the patient's tongue slightly with a gauze sponge. Use a moistened applicator to place a few crystals of salt or sugar on one side of the tongue. Wipe the tongue clean and ask the patient to identify the taste sensation.
- b. Apply a tiny amount of quinine to the base of the tongue *to test bitter taste sensation.*
- c. Place a small piece of sour pickle on the patient's tongue *to test sour taste sensation.*

2. Pinch off one nostril and ask the patient to close his eyes and sniff through the open nostril to identify nonirritating odors, such as cof-

fee, lime, and wintergreen *to evaluate sense of smell; much of what constitutes taste is actually smell.* Repeat the test on the opposite nostril.

3. Monitor and record patient's weight each week *to detect signs of weight loss.*

4. Modify the patient's diet *so he can distinguish and enjoy as many tastes as possible.* Identify ways to emphasize smell and enhance flavor of food, such as using herbs and spices *to compensate for loss of taste.*

5. Serve food in attractive surroundings. Prepare meals in an attractive manner, using a variety of different colored foods *to appeal to the patient's visual sense.*

Documentation

- Evidence of changes in patient's sense of taste
- Patient's weight
- Techniques used to modify patient's diet
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

Definition

Diminished ability to perceive position or location of body parts, especially changes in the angles of joints

Assessment

- Health history, including presence of neurologic or musculoskeletal conditions
- Musculoskeletal status, including motor coordination and muscular weakness
- Use of safety devices
- Presence of other sensory impairments
- Neurologic status, including cognition (insight, judgment, memory), level of consciousness, orientation
- Coping behaviors
- Emotional response to illness
- Self-concept, including self-esteem and body image

Defining characteristics

- Diminished motor coordination
- Inability to identify location of body part
- Inability to perceive changes in the angles of joints
- Muscular weakness, flaccidity, rigidity, or atrophy
- Paralysis

Associated medical diagnoses (selected)

Cerebral palsy, multiple sclerosis, muscular dystrophy, rhizotomy, spinal trauma, spinal tumors, surgical joint replacement

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient expresses feelings associated with changes in kinesthetic perception. (1)
- Appropriate safety precautions are implemented. (3,4,5)
- Skin breakdown is avoided, especially in areas around vulnerable joints. (6)
- Patient participates in self-care activities to maximum ability. (2,7)
- Patient participates in an appropriate exercise program. (8)

Interventions and rationales

1. Encourage patient to express feelings related to diminished kinesthetic perception *to promote acceptance of perceptual impairment.*
2. Assess changes in motor coordination, paralysis, or muscular weakness and report observations to health care team *to ensure appropriate care.*
3. Implement appropriate safety measures, such as installing padded bed rails, maintaining bed in low position, or using wheelchair lapboard *to avoid patient injury.*
4. Remind patient to regularly observe how hands and feet are placed *to avoid injury.*

5. Teach staff members to remind patient of need to check positioning of hands and feet *to ensure safety.* Emphasize the importance of communicating a patient and accepting attitude *to enhance the patient's emotional well-being.*
6. Inspect skin daily, especially areas around vulnerable joints *to detect signs of skin breakdown.*
7. Encourage use of letter board, electric wheelchair, and feeding and dressing devices *to promote independence.*
8. Provide patient with an exercise program that includes active and passive range-of-motion routines *to maintain range of motion and prevent musculoskeletal degeneration.*

Documentation

- Observations of diminished kinesthetic perception
- Evidence of patient's understanding of instructions regarding safety and protective measures and intent to use appropriate safety devices
- Patient's response to nursing interventions
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

Definition

Change in the perception of smell

Assessment

- Alterations in olfactory sense and related symptoms, including nosebleeds, foul taste in mouth, sneezing, postnasal drip, dry or sore mouth or throat, loss of sense of taste or appetite, excessive tearing, facial pain, eye pain
- Nutritional status, including weight, usual dietary intake, nausea
- Medication history, including use of phenothiazines, estrogen, metronidazole, antineoplastics, or prolonged use of nasal decongestants or topical anesthetics
- History of intranasal drug abuse, such as cocaine or amphetamines
- Respiratory status, including nasal drainage, sputum characteristics, history of colds, hay fever, or polyps
- Health status, including presence of any condition that causes irritation and swelling of

the nasal mucosa and obstruction of the olfactory area (such as nasal disease or allergies) or any condition that may cause a lesion in the olfactory nerve pathway (such as head trauma)

- Smoking history
- Inhalation of irritants, such as chlorine fumes
- Physical exam, including inspection and palpation of nasal structures, contour and color of nasal mucosa, size and color of turbinates, presence of polyps, source and character of nasal discharge, olfactory nerve (cranial nerve I) function
- Home environment, including presence of gas or propane heating systems, smoke detectors, chemical substances

Defining characteristics

- Altered sense of smell
 - a. Diminished sense of smell (hyposmia)
 - b. Absent sense of smell (anosmia)

- Diminished sense of taste and loss of appetite
- Weight changes

Associated medical diagnoses (selected)

Anterior cerebral artery occlusion, brain stem lesions, diabetes mellitus, head trauma, lead poisoning, lethal midline granuloma, nasal or sinus neoplasms, nasal polyps, nasopharyngitis, olfactory meningioma, pernicious anemia, rhinitis, septal fracture, septal hematoma, sinusitis

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- If appropriate, patient states that decreased olfactory perception is temporary. (4)
- If appropriate, patient reports improvements in olfactory perception. (1,4)
- Patient maintains weight. (2,3)
- Patient describes how to identify noxious odors and maintain a safe home environment. (6)

Interventions and rationales

1. Assess patient's ability to smell and document findings *to establish a baseline.*
2. Prepare foods that the patient likes and serve them in an attractive manner *to stimulate the patient's appetite.* Use a variety of different colored foods with each meal *to appeal to the patient's visual sense.*
3. Weigh patient weekly *to detect weight loss and monitor for possible malnutrition.*
4. If altered olfactory perception results from nasal congestion, take the following steps:
 - a. Reassure patient that condition is temporary and sense of smell should return *to diminish anxiety.* Reassure patient with nasal packing that sense of smell will re-

- turn after packing is removed and swelling decreases
 - b. Administer prescribed medications, such as antihistamines and nose drops or sprays, *to relieve nasal congestion.*
 - c. Monitor laboratory values and vital signs *to detect signs of infection.*
 - d. Record nasal drainage characteristics, including amount, color, consistency, and odor *to assess for changes in olfactory condition.*
 - e. Ensure adequate hydration and provide for humidification in patient's room *to prevent drying of mucous membranes.*
5. If altered olfactory perception doesn't result from simple nasal congestion, prepare the patient for diagnostic tests, such as sinus transillumination, skull X-ray, or computed tomography scan, as ordered, *to guide further treatment.* ‡
6. Provide home care instructions as necessary. Teach patient to:
- a. contact utility company *to implement measures for protecting against possible gas leaks.*

- b. place smoke detectors throughout home *to signal danger of fire.*
- c. discard food according to dates on packages rather than relying on sense of smell *to avoid eating spoiled food.*

Documentation

- Evidence of changes in patient's olfactory perception
- Nursing interventions performed and patient's response
- Patient's dietary preferences
- Patient's weight
- Instructions for home care and patient's or caregiver's response
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Sensory or perceptual alteration (specify)

related to sensory deprivation

138

Definition

Change in the characteristics of incoming stimuli

Assessment

- Nature of medical diagnosis
- Mobility
- Neurologic status, including cognition (insight or judgment; memory, recent and remote); level of consciousness; orientation; sensory function
- Diagnostic tests, including electroencephalogram, computed tomography scan
- Communication status, including adaptive responses (gestures, lipreading, signing), level of comprehension and expression, speech pattern
- Environmental status, including equipment and supplies, lighting, location of patient's personal belongings, noise, privacy, space
- Psychosocial status, including alcohol and drug use, behavior and personality, coping

mechanisms, history of depression, support systems

Defining characteristics

- Altered abstraction
- Altered conceptualization
- Apathy
- Change in behavior pattern
- Change in problem-solving abilities
- Disoriented to time, place, or person
- Isolation
- Reported or measured change in sensory acuity

Associated medical diagnoses (selected)

This diagnosis is often seen in elderly patients who are hospitalized or institutionalized, and in patients who are on isolation precautions. It may also occur in the following conditions: bipolar disease (depression phase), blindness, cerebrovascular accident, deafness, depression, head injury, hemianopsia, organic brain syndrome, primary or secondary dementia

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient uses adaptive equipment (glasses, hearing aid) as needed. (1)
- Patient remains oriented to time, person, and place. (2)
- Patient remains safe in environment. (3)
- Patient responds to environmental stimuli. (3,4,5,6)
- Patient or significant other communicates an understanding of sensory stimulation exercises. (5,6,7,8)
- Patient or significant other takes active role in preventing sensory deprivation and isolation. (7,8)

Interventions and rationales

1. Assist or encourage patient to use glasses, hearing aid, or other adaptive devices, *to help reduce sensory deprivation.*
2. Reorient patient to reality:
 - a. Call patient by name.
 - b. Tell patient your name.
 - c. Give background information (time, place, date) frequently throughout the day.
 - d. Orient to environment, including sights and sounds.

- e. Use large signs as visual cues.
 - f. Post patient's own photo on the door if patient is ambulatory and disoriented.
 - g. Provide for visual contrast in environment. *These measures help reduce patient's sensory deprivation.*
3. Arrange environment to offset deficit:
 - a. Place patient in room with maximal visualization of environment.
 - b. Encourage family to bring in personal articles, such as books, cards, and photos.
 - c. Keep articles in same place to promote sense of identity.
 - d. Use such safety precautions as a night light when needed. *These measures reduce sensory deprivation.*
 4. Communicate patient's response level to family or significant other and staff; record on care plan and update as needed. *Sensory deprivation level can be evaluated by response to stimuli.*
 5. Talk to patient while providing care; encourage family or significant other to discuss past and present events with patient. Arrange to be with patient at predetermined times during the day to avoid isolation. *Verbal stimuli can im-*

prove patient's reality orientation.

6. Turn on TV and radio for short periods of time based on patient's interests *to help orient patient to reality.*
7. Hold patient's hand when talking. Discuss interests with patient and family or significant other. Obtain needed items, such as talking books. *Sensory stimuli help reduce patient's sensory deprivation.*
8. Assist patient and family or significant other in planning short trips outside hospital environment. Educate about mobility, toileting, feeding, suctioning, etc. *Trips help reduce patient's sensory deprivation. ‡*

Documentation

- Patient's or significant other's expression of concern about sensory deprivation
- Observations of patient's orientation, response to environmental stimuli, and safety
- Patient's or significant other's response to nursing interventions
- Instructions and demonstration of skill in providing sensory stimuli
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Sensory or perceptual alteration (specify) related to sensory overload

139

Definition

Change in the characteristics of incoming stimuli

Assessment

- History of major trauma or surgery, seizures, alcoholism, psychiatric disorder
- Mobility status
- Neurologic status, including cognition (memory, recent and remote; insight or judgment), level of consciousness, orientation, sensory function
- Sleep-wake status
- Communication status, including adaptive responses (gestures, lip-reading, signing), level of comprehension and expression, speech pattern
- Environmental status, including equipment and supplies, lighting, location of patient's personal belongings, noise, privacy, space
- Psychosocial status, including alcohol and drug use, behavior and personality, coping

mechanisms, history of depression, support systems

Defining characteristics

- Altered abstraction
- Altered conceptualization
- Anxiety
- Bizarre thinking
- Change in behavior pattern
- Change in problem-solving abilities
- Clinical evidence of factors causing sensory overload
- Disoriented to time, place, or person
- Exaggerated emotional responses
- Hallucinations
- Irritability
- Restlessness
- Visual and auditory distortion
- Withdrawal

Associated medical diagnoses (selected)

Alcohol withdrawal syndrome, anxiety, bipolar disease (manic phase), major trauma or surgery requiring hospitalization in an intensive care unit, metabolic alkalosis

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient remains oriented to time, person, and place. (1,3,4)
- Patient voices decreased anxiety and/or irritability. (2,3,4,5,6)
- Patient communicates in a lucid manner. (2,3,4)
- Patient recognizes when sensory stimuli are excessive. (7,8,11)
- Patient reestablishes usual sleep-wake cycle. (7,10)
- Patient states measures to reduce sensory overload. (8,9,11)
- Patient demonstrates positive coping behavior when sensory overload situation arises. (8,9,11)

Interventions and rationales

1. Reorient patient to reality:
 - a. Call patient by name.
 - b. Tell patient your name.
 - c. Give background information (time, place, date) frequently.
 - d. Orient to environment, including sights, sounds, and smells. *These measures will reduce susceptibility to sensory overload.*

2. Provide a nonthreatening environment; reduce excessive noise and lights; keep environment uncluttered, *to reduce sensory overload.*
3. Accept patient's perception of stimuli. Do not challenge hallucinations or delusions; do not ridicule or tease. *Challenging patient's perceptions does not reduce sensory overload.*
4. Help patient interpret environment (for example, "This is the hospital," "I am a nurse," "You are hearing the food cart go down the hall"). *This helps reduce anxiety.*
5. Simulate "normal" environment: keep lights off (or dim) at night; let in light during day; provide clock and calendar; place family photos at bedside. *This reduces sensory overload.*
6. Explain procedures, tests, special equipment, and unusual sounds (such as alarms). Prepare patient for procedures in advance. *Increased knowledge reduces sensory overload.*
7. Cluster procedures and treatments. Avoid disturbing unnecessarily. Always approach in a calm, gentle manner to avoid startling patient. *Approaching patient in a compassionate manner helps reduce sensory overload.*
8. Help patient use coping strategies when sensory overload occurs, such as talking to

someone. *This provides a sense of control.*

9. Teach patient how to limit sensory overload; for example, turning off TV, removing self from stimulating environment. *Knowledgeable patient is better able to reduce sensory overload.*
10. Encourage regular sleep pattern and routines, possibly including milk or warm bath before bedtime. *Sufficient rest improves tolerance to stimuli.*
11. Encourage family or significant other to visit frequently; provide reassurance and explanations to aid understanding of patient's condition. *Orientation to reality through family visits helps to promote relaxation.*

Documentation

- Patient's and family's or significant other's expression of concern about sensory overload
- Observations of orientation, response to environment, anxiety level, and sleep pattern
- Patient's or significant other's response to nursing interventions
- Instructions and demonstration of skill in managing sensory overload
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

Definition

Change in the perception of touch

Assessment

- Vital signs
- Evidence of impaired tactile perception, including complaints of tingling, pain, numbness; response to sharp and dull stimulus; signs of bruises, cuts, scrapes, or other injury
- Neurologic status, including level of consciousness, cranial nerve function, muscle strength, deep tendon reflexes, and light touch, pain temperature, vibration, and position sensation
- Skin color and temperature
- History of chemotherapy treatment
- History of alcohol abuse
- Medication history, including use of clomipramine, ceftizoxime sodium, amiodarone hydrochloride, dichlorphenamide, guanadrel sulfate, anistreplase, interferon alfa-2b, zidovudine

Defining characteristics

- Altered sense of touch
 - a. Abnormal sensation, such as numbness, prickling, or tingling (paresthesia)
 - b. Decreased sensitivity to stimulation (hypoesthesia)
 - c. Diminished sensitivity to pain (hypalgesia)
 - d. Impaired sense of touch (dysesthesia)

Associated medical diagnoses (selected)

Alcoholism, arterial occlusion (acute), arteriosclerosis obliterans, arthritis, brain tumor, Buerger's disease, cerebrovascular accident, chemotherapy, diabetes mellitus, Guillain-Barré syndrome, head injury, heavy metal or solvent poisoning, herniated disk, herpes zoster, hyperventilation syndrome, hypocalcemia, migraine headache, multiple sclerosis, peripheral nerve trauma, peripheral neuropathy, polyneuropathy, rabies, Raynaud's disease, seizure disorders, spinal cord lesions, tabes dorsalis, transient ischemic attack, vitamin B deficiency

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes [†]

- Patient expresses feelings regarding changes in tactile perception. (1)
- Patient does not experience falls or injury. (2,4,5)
- Patient does not experience skin breakdown. (3)
- Patient describes safety measures he will implement to avoid injury. (5)
- Family members or caregiver describe program to provide patient with increased tactile stimulation. (6)

Interventions and rationales

1. Allow patient to express feelings associated with altered tactile perception. Be willing to listen, but do not pressure patient to talk. *Providing a chance to talk will help patient cope with sensory deficits.*
2. Teach patient to regularly observe how hands and feet are placed *to avoid injury.*
3. Inspect skin daily, especially on the patient's feet *to detect signs of skin breakdown.*
4. Use padded side rails or lapboard on wheelchair, if appropriate. Make any other environmental modifications as needed *to pro-*

mote safe tactile experiences and prevent accidental injury.

5. Teach the patient safety measures, such as testing bathwater with a thermometer or smoking cigarettes carefully *to prevent injury.*
6. Teach family members or caregiver to touch patient in areas with preserved sensation, using a variety of textures *to promote sensory input.* For example, suggest family members provide a satin pillowcase, wrap soft scarf around patient's neck, or give gentle massage with scented lotion.

Documentation

- Evidence of diminished tactile sensation
- Patient's expression of feelings about diminished tactile perception
- Instructions regarding safety and protective measures
- Patient's response to nursing interventions
- Evaluations for each expected outcome.

Care plan notes

[†] Numbers following outcomes refer to interventions.

Sensory or perceptual alteration (visual)

related to altered sensory
reception, transmission, or integration

141a

Definition

Change in the characteristics of visual stimuli

Assessment

- History of eye disorders, trauma, surgery
- Age
- Visual status, including corneal reflex, extra-ocular movement, fields of gaze, inspection of lid and eyeball, ophthalmoscopy, palpation of lid and eyeball, pupil size and accommodation, tonometry, use of glasses, visual acuity (near and distant), visual fields
- Environmental and occupational factors
- Activities of daily living
- Behavioral assessment, including coping mechanisms, support system, willingness to cooperate with treatment

Defining characteristics

- Altered conceptualization
- Anger
- Anxiety
- Apathy or passivity
- Change in behavioral pattern
- Change in problem-solving abilities
- Change in response to visual stimuli
- Clinical evidence of impaired (decreased) visual ability
- Depression
- Disoriented to time, place, person
- Reported or measured change in visual acuity
- Restlessness
- Visual distortions

Associated medical diagnoses (selected)

Albinism, blindness (uncompensated), cataracts, cerebrovascular accident; conditions requiring enucleation; detached retina, diabetes mellitus, farsightedness, glaucoma, head injury, hemianopsia, macular degeneration, multiple sclerosis, nearsightedness, optic nerve damage

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient discusses impact of visual loss on life-style. (1)
- Patient expresses a feeling of safety, comfort, and security. (2,3,4,5,6,9,10,11,12)
- Patient maintains orientation to person, place, and time. (7,8,9,10)
- Patient shows interest in external environment. (7,8)
- Patient regains visual functioning. (13,14)
- Patient compensates for visual loss by use of adaptive devices. (7,15)
- Patient plans to use appropriate resources. (16)

Interventions and rationales

1. Allow the patient to express feelings about visual loss, such as its impact on life-style. Convey a willingness to listen, but do not pressure patient to talk. *Allowing patient to voice fears aids acceptance of visual loss.*
2. Provide a safe environment by removing excess furniture or equipment from patient's room. Orient patient to the room. Show patient how to use call light. *Orienting patient to surroundings reduces safety risk.*

3. If blindness is present on admission, allow patient to direct arrangement of room; walk with patient to bathroom and other key areas until he or she becomes familiar with the environment. If patient has a seeing-eye dog, make arrangements for the feeding, exercising, and elimination needs of the dog. *Maintaining patient's optimal level of independence fosters sense of control.*
4. Modify the environment to maximize any vision the patient may have. For example, with hemianopsia, place patient in room to maximize visual field, approach patient from best visual angle, remind patient to scan environment to pick up visual cues, and place objects within visual field. *Modifying environment helps patient meet self-care needs.*
5. If patient has diplopia, patch one eye to *ameliorate double vision.*
6. Always introduce yourself or announce your presence on entering the patient's room; let patient know when you are leaving *to aid reality orientation and convey respect.*
7. Provide sensory stimulation by using tactile, auditory, and gustatory stimuli to help compensate for visual loss. Obtain large-print

books, talking books, audiotapes, or radio, as preferred by patient. *Nonvisual sensory stimulation helps patient adjust to visual loss.*

8. Provide reality orientation if patient is confused or disoriented *to allow for more effective patient-staff interaction.*

9. Give patient clear, concise explanations of treatments, procedures, etc. Avoid information overload. When speaking to patient, enunciate words clearly, slowly, and in normal speaking voice. *A knowledgeable patient will be better able to participate in treatment plan.*

10. Encourage family and friends to visit patient and to bring familiar objects that can be left with the patient. *Presence of familiar objects aids reality orientation.*

11. Make sure that health-care personnel are aware of vision loss. Record information on patient's Kardex and chart cover or post in patient's room. *Nursing care is improved if staff is aware of patient's visual loss.*

12. Respond to call light as soon as possible. Provide for continuity by assigning same staff members to care for patient, if possible. *These measures help reduce patient's fears.*

(continued)

† Numbers following outcomes refer to interventions.

Sensory or perceptual alteration (visual)

related to altered sensory
reception, transmission, or integration

141b

Interventions and rationales (continued)

13. If patient has had eye surgery, provide appropriate care, as indicated. Be aware of and limit activities that increase intraocular pressure, such as bending, stooping, getting on and off bedpan, coughing, vomiting. *Avoiding postoperative activities that increase intraocular pressure helps reduce complications.*

14. Administer and monitor effectiveness of medications. Report any adverse effects. *Medications help reduce pain and may control disease process. ‡*

15. Educate patient in alternative ways of coping with vision loss; care of such adaptive devices as eyeglasses, magnifying glass, contact lenses, and artificial eye; administration of eye drops and eye drop information, including name, dosage, therapeutic effects, and adverse effects. *Knowledgeable patient will be better able to cope with visual loss.*

16. Refer to appropriate community resources to help patient and family adapt to vision loss;

for example, American Foundation for the Blind or other community agencies or support groups. *Post-discharge support will help patient and family cope better with patient's visual loss.*

Documentation

- Patient's feelings about visual deficits
- Observations of patient's behavior, response to visual deficits, and use of adaptive equipment or devices
- Instructions regarding safety and protective measures, coping strategies, postoperative management
- Patient's and family's or significant other's intent to use appropriate resources
- Patient's response to nursing interventions
- Evaluations for each expected outcome.

Care plan notes

‡ Indicates doctor-ordered instruction.

Care plan notes

Definition

Presence of physical or emotional factors that alter one's usual pattern of sexual function

Assessment

- History of problem that caused a change in structure or function
- Patient's perception of the change's effect
- Marital status, significant other
- Living arrangement
- Usual sexual patterns
- Sexual problems before present health problem
- Patient's attitude toward modifying sexual patterns
- Patient's present knowledge about appropriate options available

Defining characteristics

- Actual or perceived limitation imposed by disease or therapy
- Alteration in relationship with spouse or significant other
- Alterations in achieving sexual satisfaction
- Change of interest in self and others
- Conflicts involving values
- Inability to achieve desired satisfaction
- Seeking confirmation of desirability
- Verbalization of the problem

Associated medical diagnoses (selected)

Chronic renal failure with hemodialysis; conditions requiring colostomy, coronary artery bypass, ileostomy, pelvic surgery, radiation therapy, radical abdominal surgery, or uretero-ileostomy; diabetes mellitus; drug therapy, such as antihypertensives, diuretics; endometriosis; genitourinary problems; myocardial infarction; pelvic inflammatory disease; rheumatoid arthritis; spinal cord injury

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient acknowledges a problem or potential problem in sexual function. (1)
- Patient voices feelings about changes in sexual identity. (2)
- Patient explains reason for sexual dysfunction. (3,7)
- Patient expresses willingness to obtain counseling. (4,5,6,8)
- Patient reestablishes sexual activity at pre-illness level. (7,8)

Interventions and rationales

1. Provide a nonthreatening atmosphere and encourage the patient to ask questions about personal sexuality. *This encourages patient to ask questions specifically related to current situation.*
2. Allow patient to express feelings openly in nonjudgmental atmosphere. *This enhances communication and understanding between patient and caregiver.*
3. Provide answers to specific questions. *This helps patient focus on specific issues, clarifies misconceptions, and builds trust in the caregiver.*

4. Provide time for privacy. *This demonstrates respect for patient, allows time for introspection, and gives patient control over time spent interacting with others.*

5. Suggest that patient discuss concerns with spouse or significant other. *This fosters sharing of concerns and strengthens relationships.*

6. Provide support for spouse or significant other. *Supportive interventions such as active listening communicate concern, interest, and acceptance.*

7. Educate patient and spouse or significant other about limitations imposed by the patient's present physical condition. *Education about limitations imposed on sexual activity by illness helps patient avoid complications or injury.*

8. Suggest referral to a sex counselor or other appropriate professional for future guidance, *to provide patient with a resource for post-discharge support.*

Documentation

- Patient's perception of problem
- Subtle comments made by patient regarding

inability to cope with change in structure or function

- Observations of patient's behavior
- Interventions performed to assist the patient and spouse or significant other; response to interventions
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

Definition

State in which an individual expresses concern about personal sexuality

Assessment

- History of present illness
- Current treatment regimen (medications, therapies)
- Marital status, significant other
- Patient's perception of sexual identity and role
- Usual sexual activity pattern
- Patient's perception of changes in sexual activity resulting from illness or treatment
- Significance of sexual relationship to patient and spouse or significant other
- Emotional reactions (affect, mood)
- Behavioral reactions (specify)

Defining characteristics

- Reported difficulties, limitations, or changes in sexual activity
- Emotional and behavioral reactions, including anger, constricted affect, depressed mood, noncompliance with prescribed therapies, withdrawal from social interactions

Associated medical diagnoses (selected)

Acquired immunodeficiency syndrome, amputation, carcinoma, coronary disease, diabetes mellitus, end-stage renal disease with hemodialysis, genitourinary problems, gynecologic problems, hypertension treated with antihypertensives, mastectomy, ostomy (colostomy, ileoconduit, ileostomy), sexually transmitted diseases (herpes, gonorrhea, syphilis), spinal cord injury with paralysis

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient voices feelings about potential or actual changes in sexual activity. (1,2,4,5)
- Patient expresses concern about self-concept, esteem, body image. (1,2,4,5)
- Patient states at least one effect of illness or treatment on sexual behavior. (3)
- Patient and spouse or significant other resume effective communication patterns. (5)
- Patient and spouse or significant other use available counseling referrals or support groups. (6)

Interventions and rationales

1. Allow for specific amount of uninterrupted time to talk with patient. *This demonstrates nurse's comfort with sexuality issues and reassures patient that his or her concerns are acceptable for discussion.*
2. Provide a nonthreatening, nonjudgmental atmosphere to encourage the patient to verbalize feelings about perceived changes in sexual identity and behaviors. *This demonstrates unconditional positive regard for patient and patient's concerns about sexuality patterns.*

3. Provide patient and spouse or significant other with information about illness and treatment. Answer any questions and clarify any misconceptions they may have. *This helps them focus on specific concerns, encourages questions, and avoids misunderstandings.*
4. Provide time for privacy. *This demonstrates respect for patient, allows time for introspection, and gives patient control over time spent interacting with others.*
5. Encourage social interaction and communication between patient and spouse or significant other. *This fosters sharing of concerns and strengthens relationships.*
6. Offer referral to counselors or support persons, such as mental health professional, sex counselor, or illness-related support groups ("I Can Cope," Reach for Recovery, Ostomy Association, etc.), *to provide patient with resources for post-discharge support.*

Documentation

- Patient's perception of changes in sexual patterns
- Patient's ability to interact with others
- Interventions to support and educate patient

- and spouse or significant other
- Response to nursing interventions
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

Definition

State in which an individual expresses concern regarding personal sexuality

Assessment

- Reason for hospitalization
- Current and anticipated length of stay
- Marital status, significant other
- Living arrangement
- Patient's perception of sexual identity and role
- Usual sexual activity pattern
- Patient's perception of limitation on sexual activity resulting from hospitalization
- Significance of sexual relationship to patient and spouse or significant other
- Emotional reactions (affect, mood)
- Behavioral reactions (specify)

Defining characteristics

- Verbal report of limitations on usual sexual behavior or activity
- Behavioral and emotional responses, including constricted affect, depressed mood, inappropriate sexual comments or behavior, withdrawal from social interaction

Associated medical diagnoses (selected)

This nursing diagnosis can occur in any hospitalized patient separated from spouse or significant other for a prolonged period. Examples include patients with infectious diseases, neurologic illnesses, orthopedic injuries, postoperative complications, terminal illnesses

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient voices feelings about changes in usual sexual activity. (1,2)
- Patient alters inappropriate behaviors, if indicated. (1,3,5)
- Patient and spouse or significant other discuss possible realistic alternatives for intimacy within hospital setting. (2,4,5)
- Patient and spouse or significant other use available counseling referrals. (6)

Interventions and rationales

1. Allow for a specific amount of uninterrupted, non-care-related time to talk with patient. *This demonstrates nurse's comfort with sexuality issues and reassures patient that his or her concerns are acceptable for discussion.*
2. Display an accepting, nonjudgmental manner to encourage patient to discuss concerns about sexuality. Approach spouse or significant other in the same manner and include in discussions with patient, if agreeable to both. *A nonjudgmental approach demonstrates unconditional positive regard for both the patient and spouse or significant other.*
3. Include patient in plan for setting limits on

inappropriate behavior, if indicated by behavioral assessment.

- a. Explain aspects of patient's behavior that are inappropriate.
 - b. Share proposed care plan with patient, including approaches for reducing bothersome behavior, expectations, and goals.
 - c. Request patient's cooperation, but be willing to compromise if acceptable alternatives are presented. *In limit-setting, patients work with nurse in planning to reduce undesirable behavior.*
4. Discuss with patient and spouse or significant other realistic, acceptable alternatives for intimacy. *This encourages open communication between them as sexual partners.* Explain limitations related to illness and hospital environment, *to establish a standard for realistic and acceptable behavior.*
 5. Provide time for privacy. *This allows patient and spouse or significant other to discuss feelings regarding sexuality and to engage in alternatives for intimacy while patient is hospitalized.*
 6. Offer referral for counseling, such as a mental health professional or a sex counselor,

if indicated. *Referrals provide opportunities for additional ongoing therapy during hospitalization and after discharge.*

Documentation

- Patient's verbal and nonverbal behaviors
- Patient's and spouse's or significant other's perception of current situation
- Specific nursing interventions to reduce emotional and behavioral reactions, such as active listening, limit setting, counseling referrals, etc.
- Patient's and spouse's or significant other's response to nursing interventions
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

Definition

Interruption in skin integrity

Assessment

- History of skin problems, trauma, surgery, immobility
- Age
- Integumentary status, including color, elasticity, hygiene, lesions, moisture, quantity and distribution of hair, sensation, temperature and blood pressure, texture, turgor
- Musculoskeletal status, including anesthetic area, joint mobility, muscle strength and mass, paralysis, range of motion
- Nutritional status, including appetite, dietary intake, hydration, present weight and change from normal
- Hemoglobin and hematocrit
- Serum albumin
- Psychosocial status, including coping skills, family or significant other, mental status, self-concept and body image

- Occupational hazards
- Knowledge: patient's current understanding of physical condition
- Patient's physical, mental, and emotional readiness to learn

Defining characteristics

- Clinical evidence of external factors adversely affecting skin integrity (chemical agents, cold, heat, pressure)
- Destruction of skin layers
- Disruption of skin surface
- Invasion of body structures

Associated medical diagnoses (selected)

Burns (chemical, thermal, electrical), extravasation from vesicants (chemotherapy, antibiotic therapy), fractures (traction, casts), hyperthermia, hypothermia, pressure ulcers, radiation therapy, surgical incision or wounds, traumatic injuries

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient exhibits no evidence of skin breakdown. (1,2,3,4,5,6,7,8)
- Patient shows normal skin turgor. (1,2,3,4)
- Patient regains skin integrity; for example, pressure ulcer decreases in size (specify). (2,3,7,8)
- Surgical wound healed. (2,7,8)
- Patient communicates understanding of skin protection measures. (7,8)
- Patient demonstrates skill in care of wound or burn or incision. (7,8)
- Patient demonstrates skin inspection technique. (7)
- Patient performs skin care routine. (7,8)
- Patient communicates feelings about change in body image. (6,9)

Interventions and rationales

1. Inspect skin every shift; describe and document skin condition; report changes. *This provides evidence of effectiveness of skin care regimen.*
2. Perform prescribed treatment regimen for skin condition involved; monitor progress. Report responses to treatment regimen, *to main-*

tain or modify current therapy. ‡

3. Provide supportive measures, as indicated.
 - a. Assist with general hygiene and comfort measures, *to promote comfort and sense of well-being.*
 - b. Administer pain medication and monitor its effectiveness. *Pain relief is needed to maintain health.* ‡
 - c. Maintain proper environmental conditions, *to promote sense of well-being.*
 - d. Use foam mattress, bed cradle, or other devices, *to avoid skin breakdown.*
 - e. Warn against tampering with wound or dressings, *to avoid potential infection.*
 - f. Maintain infection control standards, *to reduce risk of spreading disease.*
4. Position patient for comfort and minimal pressure on bony prominences. Change position at least every 2 hours. Monitor frequency of turning and skin condition. *These measures reduce pressure, promote circulation, and avoid skin breakdown.*
5. Explain therapy to patient and family or significant other, *to encourage compliance.*
6. Allow patient to express feelings regarding skin problem. *This helps allay anxiety and de-*

velops coping skills.

7. Instruct patient and family or significant other in skin care regimen, *to encourage compliance.*
8. Supervise patient and family or significant other in skin care management. Provide feedback, *to improve skill in managing skin care.*
9. Make referral to psychiatric liaison nurse, social service, or other support groups, as indicated. *These provide additional support for patient and family.*

Documentation

- Patient's concerns about change in skin integrity, willingness to accept treatment, and participation in treatment regimen
- Observations of wound and incision healing and response to treatment regimen
- Interventions to provide supportive care and prescribed treatment
- Patient's response to nursing interventions
- Patient's and family's or significant other's understanding and skill in performing skin care measures
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Definition

Interruption in skin integrity

Assessment

- History of skin problems, trauma, chronic debilitating disease, immobility
- Age
- Integumentary status, including color, elasticity, hygiene, lesions, moisture, quantity and distribution of hair, sensation, temperature and blood pressure, texture, turgor
- Musculoskeletal status, including anesthetic area, joint mobility, muscle strength and mass, paralysis, range of motion
- Nutritional status, including appetite, dietary intake, hydration, present weight or change from normal
- Hemoglobin and hematocrit
- Serum albumin
- Psychosocial status, including coping patterns, family or significant other, mental status, occupation, self-concept and body image

- Knowledge, including patient's current understanding of physical condition; patient's physical, mental, and emotional readiness to learn

Defining characteristics

- Clinical evidence of internal factors adversely affecting skin integrity
- Destruction of skin layers
- Disruption of skin surfaces
- Invasion of body structures

Associated medical diagnoses (selected)

Anasarca, anemia, chronic renal disease, dermatologic conditions (allergic or atopic dermatitis, drug-induced dermatitis), diabetes mellitus, Laennec's cirrhosis, malnutrition, neuromuscular disorders, peripheral vascular disorders (venous and arterial ulcers), terminal cancer

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient exhibits improved or healed lesions, wounds. (1,2,3,7,8,9)
- Patient states increased comfort. (2,3)
- Complications avoided or minimized. (1,2,3)
- Patient correlates precipitating factors with appropriate skin care regimen. (5,6,9)
- Patient explains skin care regimen. (5,6,7)
- Patient and family or significant other demonstrates skin care regimen. (8)
- Patient voices feelings about changed body image. (4,10)

Interventions and rationales

1. Inspect skin every shift; describe and document skin condition; report changes. *This provides evidence of effectiveness of skin care regimen.*
2. Perform prescribed treatment regimen for skin condition involved; monitor progress. Report favorable and adverse responses to treatment regimen, *to maintain or modify current therapies as needed.* ‡
3. Provide supportive measures, as indicated:
 - a. Assist with general hygiene and comfort measures, *to promote comfort and gen-*

eral sense of well-being.

- b. Administer pain medications and monitor effectiveness. *Pain relief is needed to maintain health.* ‡
 - c. Maintain proper environmental conditions, including room temperature and ventilation. *Providing comfortable environment promotes sense of well-being.*
 - d. Apply bed cradle *to protect lesions from bed covers.*
 - e. Remind patient not to scratch, *to avoid skin injury.*
 - f. Administer and monitor effectiveness of antipruritic medications. *Antipruritics reduce itching sensation.* ‡
 - g. Explain dietary restrictions, for example, from skin allergy to food. *Resulting pruritus leads to skin breakdown.*
4. Encourage patient to express feelings about skin condition *to enhance coping.*
 5. Explain therapy to patient and family, *to encourage compliance.*
 6. Discuss precipitating factors, if known, and the long-term effects of skin integrity interruption. *Knowledge of precipitating factors helps patients reduce their occurrence and severity.*

7. Instruct patient and family in skin care regimen, *to ensure compliance.*
8. Supervise patient and family in skin care regimen. Provide feedback. *Practice helps improve skill in managing skin care regimen.*
9. Encourage adherence to other aspects of health-care management *to control or minimize effects on skin.*
10. Refer patient to psychiatric liaison nurse, social service, or support group, as appropriate. *These provide additional support for patient and family.*

Documentation

- Patient's concerns about skin disorder and its impact on body image and life-style
- Patient's willingness to participate in care
- Observations of skin condition, healing, and response to treatment regimen
- Interventions to provide supportive care
- Instructions regarding treatment regimen
- Patient's or family's understanding of and skill in carrying out instructions
- Patient's response to nursing interventions
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Definition

Presence of risk factors for interruption or destruction of skin surface

Assessment

- History of skin problems, trauma, chronic debilitating disease, immobility
- Age
- Integumentary status, including color, elasticity, hygiene, lesions, moisture, sensation, quantity and distribution of hair, temperature and blood pressure, texture, turgor
- Musculoskeletal status, including anesthetic area, muscle strength and mass, joint mobility, paralysis, range of motion
- Nutritional status, including appetite, dietary intake, hydration, present weight and change from normal
- Hemoglobin and hematocrit
- Serum albumin
- Psychosocial status, including activities of

daily living, mental status, occupation (sun exposure), recreational activities

Risk factors

- External (environmental) factors, including pressure, friction, shearing forces, restraints, physical immobilization, confinement to bed or chair, excretions and secretions, moisture, hypothermia or hyperthermia.
- Internal (somatic) factors, including altered nutritional status (cachexia or debilitation), decreased serum albumin, dehydration, dependence on others for self-care, skin maceration, bladder or bowel incontinence, comatose state, paralysis, skeletal prominences, decreased circulation, obesity, localized infection in pressure-supporting areas, loss of subcutaneous tissue or muscle mass, altered metabolic state, vitamin deficiency

Associated medical diagnoses (selected)

Anasarca; chronic hepatitis; cerebrovascular accident₁; chronic renal disease; cirrhosis (ascites); conditions requiring colostomy, gastrotomy, nephrostomy, or ureteroileostomy; diabetes mellitus; fractures (traction, cast); frostbite; malnutrition; neuromuscular disorders; peripheral vascular disease; spinal cord injury; sunburn; terminal cancer. This diagnosis may occur in any patient who is on prolonged bed rest or is immobilized.

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes [†]

- Patient experiences no skin breakdown. (1,2,3,4,5,6,7,8,9,10,11,12,13)
- Patient maintains muscle strength and joint range of motion. (2,3)
- Patient sustains adequate food and fluid intake. (9)
- Patient maintains adequate skin circulation. (2,3)
- Patient communicates understanding of preventive skin care measures. (10,12)
- Patient and family demonstrate preventive skin care measures. (13)
- Patient and family correlate risk factors and preventive measures. (10,11,12)

Interventions and rationales

1. Inspect skin every shift; document skin condition and report any status changes. *Early detection of changes prevents or minimizes skin breakdown.*
2. Change patient's position at least every 2 hours; follow turning schedule posted at bedside. Monitor frequency of turning. *These measures reduce pressure on tissues, promote circulation, and avoid skin breakdown.*

3. Encourage ambulation or perform or assist with active range-of-motion exercises at least every 4 hours while patient is awake. *Exercises prevent muscle atrophy and contractions; ambulation promotes circulation and relieves pressure.*
4. Use preventive skin care devices as needed, such as a foam mattress, an alternating pressure mattress, sheepskin, pillows, or padding, *to avoid discomfort and skin breakdown. These measures do not replace need for turning.*
5. Keep patient's skin clean and dry; lubricate as needed. Avoid use of irritating soap; rinse skin well. *These measures alleviate skin dryness, promote comfort, and reduce risk of irritation and skin breakdown.*
6. Protect bony prominences with foam padding and massage gently to increase circulation. *Prominences have little subcutaneous fat and are prone to breakdown; massage increases circulation and promotes skin integrity.*
7. Lift patient's body when moving; avoid shearing force. *Shearing force is caused when tissues slide against each other; a lifting*

sheet reduces sliding.

8. Keep linen dry, clean, and free of wrinkles or crumbs. Change wet bed linens and incontinence pads immediately. *Dry, smooth linens avoid excoriation and skin breakdown.*
9. Monitor nutritional intake; maintain adequate hydration. *Anemia (< 10 mg Hgb) and low serum albumin (< 2 mg) are associated with development of pressure ulcers. Hydration helps maintain skin integrity.*
10. Educate patient and family in preventive skin care: maintaining good personal hygiene; using nonirritating (nonalkaline) soap; patting rather than rubbing to dry skin; inspecting skin on a regular basis; avoiding prolonged exposure to water, sun, cold, wind; avoiding rubber rings; recognizing beginning skin breakdown (redness, blisters, discoloration); and reporting symptoms. *These measures encourage compliance with skin care regimen.*
11. Indicate risk factor potential on patient's chart and care plan. For example, "Patient risk is 5 on a scale of 1 to 10." *Risk factor score helps evaluate treatment progress.*
12. Explain why preventive skin care mea-

(continued)

[†] Numbers following outcomes refer to interventions.

Interventions and rationales (continued)

asures are needed, *to encourage compliance with skin care regimen.*

13. Supervise patient and family in preventive skin care measures. Give constructive feedback. *Practice helps improve skill in managing skin care regimen.*

Documentation

- Patient's and family's expression of concern about potential skin breakdown
- Observations of risk factors and skin condition
- Use of preventive skin care devices and their effectiveness
- Instructions regarding preventive skin care; patient's and family's understanding of instructions
- Patient's and family's demonstrated skill in carrying out preventive skin care measures
- Patient's response to nursing interventions
- Evaluations for each expected outcome.

Care plan notes

Care plan notes

Definition

Inability to meet individual need for sleep or rest arising from internal or external factors

Assessment

- Daytime activity and work patterns
- Normal bedtime
- Usual number of hours of sleep required
- Problems associated with sleep, including early-morning awakening, falling asleep, nightmares, sleepwalking, staying asleep
- Quality of sleep
- Sleeping environment
- Activities associated with sleep
- Personal beliefs about sleep
- Chemical ingestion, including alcohol, caffeine, hypnotics, nicotine

Defining characteristics

- Awakening earlier or later than desired
- Changes in behavior or performance, including disorientation, increased irritability, lethargy, listlessness, restlessness
- Evidence of external factors that prevent or disrupt sleep
- Interrupted sleep
- Physical signs, including dark circles under eyes; expressionless face; frequent yawning; mild, fleeting nystagmus; ptosis of the eyelid; slight hand tremor; thick speech with mispronunciation or incorrect words
- Verbal complaints of difficulty falling asleep
- Verbal complaints of not feeling well-rested

Associated medical diagnoses (selected)

This diagnosis may affect elderly, hospitalized patients, patient sharing a room with someone confused and noisy, and patients whose treatment involves any of the following: Frequent monitoring of vital signs, intensive care, mechanical ventilation, medications during the night, treatments given during the night

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient identifies factors that prevent or facilitate sleep. (1,2)
- Patient sleeps _____ hours without interruption. (3,4,5,6)
- Patient expresses feeling of being well-rested. (7)
- Patient shows no physical signs indicative of sleep deprivation. (8)
- Patient alters diet and habits to promote sleep; for example, reduces caffeine, limits alcohol intake. (9)
- Patient exhibits no sleep-related behavioral symptoms, such as restlessness, irritability, lethargy, disorientation. (3,4,5,6,7,8)
- Patient performs relaxation exercises at bedtime. (8)

Interventions and rationales

1. Ask patient what environmental factors make sleep difficult. *Sleeping in strange or new environment tends to influence both REM and NREM sleep.*
2. Ask patient what changes would facilitate sleep. *This allows patient to take active role in treatment.*

3. Make whatever immediate changes are possible to accommodate patient; for example, reduce noise, change lighting, close door. *These measures promote rest and sleep.*
4. Plan medication administration schedules to allow for maximum rest. If patient requires diuretics in the evening, give far enough in advance to allow peak effect before bedtime.
5. Make a detailed plan to provide the patient with _____ hours of uninterrupted sleep, if possible. *This allows consistent nursing care and gives patient uninterrupted sleep time.*
6. Provide patient with normal sleep aids, such as pillow, bath, back rub, food, drink. *Milk and some high protein snacks such as cheese or nuts contain L-tryptophan, a sleep promoter. Personal hygiene routine precedes sleep in many patients.*
7. Ask patient to describe in specific terms each morning the quality of sleep during the previous night. *This helps detect presence of sleep-related behavioral symptoms.*
8. Teach patient such relaxation techniques as guided imagery, meditation, progressive muscle relaxation. Practice them with patient at bedtime. *Purposeful relaxation efforts often*

help promote sleep.

9. Instruct patient to eliminate caffeine from diet, limit alcohol intake, and avoid foods that interfere with sleep (for example, spicy foods). *Foods and beverages containing caffeine should be avoided for 4 to 5 hours before bedtime.*

Documentation

- Patient's complaints about sleep disturbances
- Patient's verbalization of feelings in relation to sleep
- Observations of behavior indicative of sleep deprivation
- Interventions to alleviate sleep disturbance
- Patient's response to nursing interventions
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

Sleep pattern disturbance

related to internal factors, such as illness,
psychological stress, drug therapy, biorhythm disturbance

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Definition

Inability to meet individual need for sleep or rest arising from internal or external factors

Assessment

- Age
- Daytime activity and work patterns
- Time the patient usually retires
- Number of hours of sleep patient usually requires in order to feel rested
- Problems associated with sleep, including early-morning awakening, falling asleep, nightmares, sleepwalking, staying asleep
- Quality of sleep
- Sleeping environment
- Activities associated with sleep, including bath, drink, food, medication
- Personal beliefs about sleep

Defining characteristics

- Awakening earlier or later than desired
- Changes in behavior or performance, including disorientation, increased irritability, lethargy, listlessness, restlessness
- Evidence of internal factors that prevent or disrupt sleep
- Interrupted sleep
- Physical signs, including dark circles under eyes; expressionless face; frequent yawning; mild, fleeting nystagmus; ptosis of the eyelid; slight hand tremor; thick speech with mispronunciation and incorrect words
- Verbal complaints of difficulty falling asleep

Associated medical diagnoses (selected)

Alcoholism, bipolar disorder (manic-depressive), chronic obstructive pulmonary disease, depression, drug addiction, Pickwickian syndrome, sleep apnea

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient identifies factors that prevent or disrupt sleep. (1)
- Patient sleeps _____ hours a night. (2,3,4,5,6)
- Patient expresses feeling of being well-rested. (7)
- Patient shows no physical signs of sleep deprivation. (8)
- Patient exhibits no sleep-related behavioral symptoms, such as restlessness, irritability, lethargy, disorientation. (3,4,5,6,7,8)
- Patient performs relaxation exercises at bedtime. (8)

Interventions and rationales

1. Allow patient to discuss any concerns that may be preventing sleep. *Active listening aids determination of causes of difficulty with sleep.*
2. Plan nursing care routines to allow _____ hours of uninterrupted sleep. *This allows consistent nursing care and gives patient uninterrupted sleep time.*
3. Provide patient with usual sleep aids, such as pillows, bath before sleep, food or drink,

reading materials, etc. *Milk and some high protein snacks such as cheese and nuts contain L-tryptophan, a sleep promoter. Personal hygiene routine precedes sleep in many patients.*

4. Create a quiet environment conducive to sleep; for example, close the curtains, adjust the lighting, close the door. *These measures promote rest and sleep.*

5. Administer medications that promote normal sleep patterns, as ordered. Monitor and record side effects and effectiveness. *A hypnotic agent induces sleep; a tranquilizer reduces anxiety. ‡*

6. Promote involvement in diversional activities or exercise program during the day. Discuss the relationship of exercise and activity to improved sleep. Discourage excessive napping. *Activity and exercise promote sleep by increasing fatigue and relaxation.*

7. Ask patient to describe in specific terms each morning the quality of sleep during the previous night. *This helps detect presence of sleep-related behavioral symptoms.*

8. Educate patient in such relaxation techniques as imagery, progressive muscle relaxa-

tion, meditation. *Purposeful relaxation efforts often help promote sleep.*

Documentation

- Patient's complaints about sleep disturbances
- Patient's report of improvement in sleep patterns
- Observations of physical and behavioral sleep-related disturbances
- Interventions to alleviate sleep disturbances
- Patient's response to nursing interventions
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Definition

Insufficient quantity or ineffective quality of social exchange

Assessment

- Reason for hospitalization (physiologic, psychiatric)
- Usual pattern of social interaction (nonverbal behaviors, verbal communication)
- Neurologic functioning, including level of consciousness, orientation, sensory and motor ability
- Mental status, including abstract ability, affect, concentration ability, insight and judgment, memory, mood, thought content
- History of substance abuse
- Education and intelligence level
- Sociocultural background, including beliefs, norms, religion, values
- Support systems available, including clergy, family or significant other, friends

Defining characteristics

- Delusional thinking
- Observed use of unsuccessful or dysfunctional social interaction skills
- Observed or verbalized discomfort in social interaction skills
- Sensory and perceptual alterations, including auditory, visual, or tactile hallucinations
- Verbalized or observed inability to communicate needs or to receive a sense of need-gratification from caregivers

Associated medical diagnoses (selected)

Alzheimer's disease, brain tumor, cerebrovascular accident, diabetic ketoacidosis, drug or alcohol withdrawal, head trauma, organic brain syndrome, psychiatric disorder

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient remains free of injury. (2,4)
- Patient and family or significant other report concern about difficulties in social interaction. (3,4)
- Patient maintains orientation to time, place, and person. (3)
- Patient's perceptions are reality-based. (4)
- Patient and family or significant other participate in care and prescribed therapies. (3,7,8)
- Patient expresses needs and communicates whether needs are met. (5,6)
- Patient regains appropriate neurologic function to the extent possible. (1)
- Patient demonstrates effective social interaction skills in both one-on-one and group settings. (5,6)
- Patient and family or significant other identify and mobilize resources for rehabilitation and discharge planning, as necessary. (8)

Interventions and rationales

1. Follow medical regimen to treat underlying condition. *Nurse is responsible for following medical regimen and working with doctor to plan appropriate care.* ‡

2. Take precautions to ensure safe and protected environment (provide side rails, assistance with out-of-bed activities, uncluttered room, physical restraints, as necessary). *This reduces potential for patient injury.*
3. Assess neurologic function and mental status every shift *to monitor changes in patient's status*, and reorient patient as often as necessary:
 - a. Call patient by name and say your name each time you interact with patient.
 - b. Tell patient correct day, date, time, and place at least once a shift.
 - c. Teach family how to reorient patient and assist them in doing so.
 - d. Ask family or significant other to bring patient familiar objects from home, such as clock, radio, or photographs.
 - e. Post structured schedule of daily activities in patient's room within visual range.
 - f. Explain structure to family or significant other and other caregivers to provide consistency and continuity. *Reorienting patient and involving family or significant other enhances patient's reality testing ability and overall mental status. Scheduling*

daily routine narrows patient's frame of reference, thereby decreasing potential for increased confusion.

4. If delusions and hallucinations occur, do not focus on them; provide patient with reality-based information and reassure patient of safety. *This increases patient's ability to grasp reality and reduces fears associated with these disturbances.*
5. Provide specific, non-care-related time with patient each shift to encourage social interaction. Begin with one-on-one interaction and increase to group interaction as patient's skills indicate. *Gradually increasing social interaction reduces patient's feeling of being overwhelmed and eliminates sensory input that may renew cognitive or perceptual disturbance.*
6. Give positive reinforcement for appropriate and effective interaction behaviors (verbal and nonverbal). *This helps patient recognize progress and enhances feelings of self-worth.*
7. Assist patient and family or significant other in progressive participation in care and therapies. *This reduces feelings of helplessness*

(continued)

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Interventions and rationales (continued)

and enhances patient's feeling of control and independence.

8. Initiate or participate in multidisciplinary patient-centered conferences to evaluate progress and plan discharge. In addition to patient and family or significant other, conferences may include physical, occupational, and speech therapists; social worker; attending doctor; and other consultants, as necessary. *These conferences involve patient and family in cooperative effort to develop strategies for altering care plan as necessary.*

Documentation

- Patient's verbal and nonverbal behaviors
- Neurologic and mental status assessment
- Observations of patient's social interaction skills
- Interventions to facilitate appropriate and effective social interaction
- Patient's responses to nursing interventions
- Evaluations for each expected outcome.

Care plan notes

Care plan notes

Definition

Insufficient quantity or ineffective quality of social exchange

Assessment

- Reason for hospitalization (physiologic, psychiatric)
- Sociocultural background (beliefs, norms, rituals, values)
- Usual pattern of social interaction, including dominant language, group participation, level of comprehension, nonverbal communication skills (drawing, gestures), speech pattern
- Patient's position in family
- Support systems available, including clergy, family or significant other, friends
- Education and intelligence level

Defining characteristics

- Observed use of unsuccessful social-interaction behavior
- Verbalized or observed discomfort in situations requiring social exchange
- Verbalized or observed inability to communicate needs or to receive a sense of need-gratification from caregivers

Associated medical diagnoses (selected)

This diagnosis can occur in any hospitalized patient separated from usual sociocultural environment. For example, in some European and Oriental cultures, nonverbal means of communication (eye contact, touch) are considered an invasion of privacy; many Native Americans consider social interaction outside the family to be disloyal.

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient provides information concerning cultural background. (1,2,4)
- Patient identifies needs and communicates (verbally or nonverbally) whether needs are met. (2,3,4,5,6,7)
- Patient expresses an understanding of care-related instruction. (1,3,5)
- Patient and family or significant other participate in planning care. (5)
- Patient identifies effective coping techniques to deal with sociocultural differences. (6)
- Patient and family or significant other express feelings of comfort and trust in interaction with caregivers. (1,5,6)
- Patient uses resources outside normal sociocultural group, as necessary. (8)

Interventions and rationales

1. Assign a primary nurse to this patient, if possible. *Primary nursing provides consistency, enhances trust and decreases potential for fragmented care.*
2. Provide specific time (for example, 10 minutes each shift) to talk with patient and family or significant other about sociocultural back-

ground. *In many cultural groups, trust is developed slowly and may be hampered by lengthy interviews.*

3. Explain care-related activities clearly, answering questions as accurately as possible. *This enhances patient's understanding of care-related procedures and hospital routine.*
4. Use an interpreter when necessary, to ensure effective communication for non-English-speaking patients.
5. Involve patient and family or significant other in planning care, and encourage patient's participation in self-care on a continuing basis. *This increases their sense of control and reduces feelings of helplessness and isolation.*
6. Assist patient in identifying and using effective social-interaction behaviors, such as increased eye contact, calling person by name, asking questions, etc. *Teaching patient effective intrapersonal communication is an essential part of nursing practice.*
7. Demonstrate respect for patient's privacy, personal belongings, cultural norms, and religious beliefs and practices, to provide sensitive care to patients from varied cultural

backgrounds.

8. Offer referral to other support systems, if indicated (such as social services, financial counseling, home health care, mental health care, professional care). *This ensures a comprehensive approach to patient's care.*

Documentation

- Patient's and family's or significant other's perception of current situation
- Interventions to facilitate effective social interaction
- Patient's verbal and nonverbal responses to nursing interventions
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

Definition

Aloneness that the patient perceives negatively. This social isolation may be self-imposed or be perceived by the patient as being imposed by others. Alternately, the isolation may result from environmental factors.

Assessment

- Reason for hospitalization (physiologic, psychiatric)
- Support systems available, including clergy, family, relatives, or friends
- Functional ability
- Diversional interests
- Attitudes of family or friends toward patient
- Financial resources
- Occupation
- Education level
- Coping and problem-solving ability
- Self-esteem

Defining characteristics

- Culturally unacceptable behavior
- Describes life-style as solitary or circumscribed by membership in subculture
- Evidence of physical or mental handicap or altered state of wellness
- Expresses feelings of being different from others
- Expresses feelings of rejection or aloneness
- Expresses frustration over inability to meet expectations of others
- Inappropriate or immature interests or activities
- Insecurity in public
- Lack of family, friends, and social groups
- Lack of purpose in life
- Preoccupation with own thoughts
- Projects hostility in voice and behavior
- Repetitive, meaningless actions
- Sad, dull affect
- Uncommunicative, withdrawn, poor eye contact

Associated medical diagnoses (selected)

Acquired immunodeficiency syndrome, Alzheimer's disease (early stage), cancer, depression, disorders requiring isolation precautions, genital herpes, head or neck surgery, hepatitis, organic brain syndrome, schizophrenia, spinal cord injuries, tuberculosis

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes [†]

- Patient expresses feelings associated with social isolation. (1,2,4,6)
- Patient identifies causes of social isolation and participates in developing a plan for increasing social activity. (2,3,4)
- Patient interacts with family or friends. (4,8)
- Patient interacts with staff members. (1,2,6)
- Patient performs self-care activities independently. (5)
- Patient participates daily in a meaningful diversional activity (specify). (7)
- Patient indicates social relationships have improved, and negative feelings have diminished. (4,6,8,9)
- Patient achieves expected state of wellness. (10)

Interventions and rationales

1. Assign a primary nurse to the patient, if possible, *to provide continuity, enhance trust, and decrease potential for fragmented care.*
2. Initiate a trusting nurse-patient relationship *to help gain the patient's confidence.*
3. Provide honest and immediate feedback about the patient's behavior, *to help the pa-*

tient become aware of the effects of behavior and to modify, verify, or correct patient's perceptions.

4. Help patient to identify causes of social isolation *to identify patient's needs and guide planning of care.* Involve patient and family or friends in setting goals and planning care *to individualize plan of care and decrease patient's feelings of helplessness and isolation.*

5. Encourage patient to perform such self-care activities as bathing, grooming, dressing, eating, and ambulating *to reduce helplessness and foster independent action.*

6. Spend at least 15 minutes each shift with the patient. Sit with the patient and listen. *Listening communicates concern, interest, and acceptance; and allows time for the patient to collect thoughts and express feelings.*

7. Arrange with the patient for specific periods of appropriate planned diversional activity *to provide pleasure, increase feelings of self-worth, and decrease negative self-absorption.*

8. Allow ample private time for the patient to spend with family and friends *to demonstrate respect for the patient and for the patient's relationships with others.*

9. Identify appropriate social agencies and support groups for patient and provide referrals *to ensure ongoing opportunities for the patient to increase social interaction.*

10. Educate the patient and family about health care needs and treatment *to promote optimal health and well-being, thereby allowing for greater social activity.*

Documentation

- Observations of patient's social interaction skills
- Causes of social isolation identified by patient
- Resources identified to help patient increase social interaction
- Interventions to encourage social interaction and patient's response
- Evaluations for each expected outcome.

[†] Numbers following outcomes refer to interventions.

Definition

Self-imposed or environmentally imposed lack of contact with support systems

Assessment

- Reason for hospitalization (physiologic, psychiatric)
- Support systems available, including clergy, family or significant other, friends
- Diversional interests
- Attitudes of family or significant other toward patient in this situation
- Financial resources
- Occupation
- Level of education and intelligence
- Coping and problem-solving ability
- Self-esteem

Defining characteristics

- Absence of support system, including family or significant other, friends, support group
- Displays behavior unacceptable to dominant cultural group
- Evidence of insufficient resources to meet societal expectations
- Expresses feelings of aloneness or rejection
- Projects hostility in voice, behavior
- Sad, dull affect
- Seeks to be alone or exists in subculture
- Uncommunicative, withdrawn

Associated medical diagnoses (selected)

This diagnosis occurs among elderly patients, street persons, patients with present or past history of psychiatric disorders, and patients who have no family or friends to support them

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient interacts with caregivers in a positive way. (1,2)
- Patient expresses feelings about lack of supportive relationships. (3)
- Patient expresses desire to be involved with others. (4,5)
- Patient expresses desire to improve self and present condition; for example, by obtaining further education or learning how to better manage finances. (5,6)
- Patient uses resources available through the agency (social services, home health care, psychology services, self-improvement classes) to establish a realistic plan for the future. (6)
- Patient states plan to participate in social activity. (7)

Interventions and rationales

1. Assign same caregivers to patient to promote trusting relationships with staff members. *Consistent care promotes patient's ability to communicate openly.*
2. Assign a primary nurse to coordinate patient's care. *This reduces potential for frag-*

mented nursing interventions.

3. Plan a 15-minute period to sit with patient each shift. If patient does not wish to talk, remain silent. *Active listening communicates concern, allows time to collect thoughts, and encourages patient to initiate interaction.*
4. Involve patient in planning care; have patient participate in self-care continuously. *This provides structure, reduces feelings of helplessness, and fosters independent action.*
5. Discuss patient's living accommodations and life-style outside the hospital. *Knowledge of patient's current life-style and accommodations aids understanding of patient's uniqueness and helps with discharge planning.*
6. Refer to social services for follow-up, if necessary, *to ensure a comprehensive approach to care.*
7. Help patient identify social outlets (peer group, association, participation in group activity). *This draws patient's attention to specific data and promotes goal-directed interaction.*

Documentation

- Patient's perceptions of the present situation
- Patient's expressions of plans for the future
- Observations of patient's behavior
- Planning done by patient with nurse, physician, social worker, etc.
- Patient's response to nursing interventions
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

Definition

Separation or alienation from religious traditions or values

Assessment

- Religious ties and practices
- Religious commitment
- Visits (church members, family members, or clergy)

Defining characteristics

- Can't or won't participate in usual religious practices
- Expresses concern with meaning of life and death or belief systems
- Questions meaning of own existence
- Questions the meaning of suffering
- Seeks spiritual assistance
- Shows anger toward God (as defined by the patient)
- Shows displacement of anger toward religious representatives
- Voices inner conflicts about beliefs

Associated medical diagnoses (selected)

This diagnosis may be seen in any hospitalized patient, depending on the individual and the circumstances

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient communicates conflict about beliefs. (1,2)
- Patient identifies the source of spiritual conflict. (3,4)
- Patient specifies whatever spiritual assistance is needed. (5,6,7)
- Patient discusses beliefs regarding religious practices. (8,9)
- Patient identifies coping techniques to deal with spiritual discomfort. (1,2,3,4,5,6,7,8,9)
- Patient expresses feelings of spiritual comfort. (3,4,5,6,7,8,9)

Interventions and rationales

1. Listen for cues indicative of patient's feelings ("Why did God do this to me?" or "God is punishing me"). *Active listening demonstrates involvement with patient and allows nurse to hear important messages indicating spiritual distress.*
2. Approach patient in a nonjudgmental way, to focus on patient's feelings without evaluating them as right or wrong, good or bad.
3. Acknowledge patient's spiritual concerns, and encourage expression of thoughts and

feelings, to help build a therapeutic relationship.

4. Help patient define in concrete terms the problem causing the inner conflict. *This is first step in developing strategies for resolving conflicts.*

5. Arrange for visits by clergy, as appropriate, thereby using expert spiritual care resources to help the patient.

6. Encourage patient to continue religious practices during hospitalization; do whatever is necessary to facilitate this. For example:

- a. If patient is accustomed to reading the Scriptures and doesn't have a Bible, make an effort to get one.
- b. If Jewish male wears a yarmulke, allow him to continue wearing it if possible.
- c. In cases where certain foods are prohibited or special foods are required, according to patient's religious traditions, make every effort to communicate these needs to the dietary department and see that they are honored. *These measures demonstrate support and convey caring and acceptance to patient.*

7. Communicate and collaborate with patient's

minister or with the hospital chaplain, when this is appropriate. *This ensures consistent care and provides more complete data base.*

8. Arrange for patient to have at the bedside objects that provide spiritual comfort (Bible, prayer shawl, pictures, statues, rosary beads). *Items of spiritual significance may influence patient's ability to reduce conflict.*

9. Provide privacy during patient's visits with minister or chaplain, to demonstrate respect for patient's relationship with clergy.

Documentation

- Patient's expressions of concern about spiritual matters, whether direct or subtle
- Observations about patient's spiritual distress or well-being
- Interventions carried out to promote spiritual comfort
- Observations about patient's responses to interventions
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

Definition

Separation or alienation from religious tradition or values

Assessment

- Reason for hospitalization
- Religion or church affiliation
- Patient's usual and current perception of faith and religious practices
- Available spiritual support persons (minister, priest, rabbi)

Defining characteristics

- Expresses concern with meaning of life and death
- Engages in "bargaining" with God (as defined by individual) as stage of anticipatory grieving
- Demonstrates anger toward God, church, and clergy
- Verbalizes guilt about self and behavior
- Reports ambivalence about faith and religious practices

Associated medical diagnoses (selected)

This nursing diagnosis can apply to any hospitalized individual with strong religious beliefs and practices. It is particularly evident in those experiencing the threat of death.

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient expresses feelings about usual and current religious beliefs. (1,2,3)
- Patient identifies areas of ambivalence and conflict resulting from current situation. (1,2,3,5)
- Patient states an understanding of the grief process and its stages. (4)
- Patient uses effective coping strategies to ease spiritual discomfort. (4,5,6,7)
- Patient seeks appropriate support persons (family or significant other, priest, minister, rabbi) for assistance. (6,7)

Interventions and rationales

1. Approach patient in an accepting, nonjudgmental manner, *to demonstrate unconditional positive regard for the patient.*
2. Acknowledge patient's spiritual concerns and encourage expression of feelings, *to help build a therapeutic relationship.*
3. Encourage patient to provide information about religious beliefs and practices. *Acquiring this initial data base is first step in nursing process.*
4. Instruct patient on the stages of grieving

and on the emotions and behaviors common to each stage. *This promotes understanding and encourages feelings of normalcy.*

5. Provide for continuation of patient's religious practices (allow for specific religious materials or clothing; respect dietary restrictions if possible). *These measures demonstrate support and convey caring and acceptance to patient.*
6. Facilitate visits from clergy and provide privacy during visits, *to demonstrate respect for patient's relationship with clergy.*
7. Encourage patient to discuss concerns with clergy, *thereby using expert spiritual care resources to help the patient.*

Documentation

- Patient's verbal and nonverbal communication of spiritual discomfort
- Stage of anticipatory grief as indicated by behavior
- Interventions to promote spiritual comfort
- Patient's response to nursing interventions
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

Definition

*Accentuated risk of accidental suffocation
(inadequate air available for inhalation)*

Assessment

- Health history, including accidents, allergies, exposure to pollutants, falls, hyperthermia, hypothermia, poisoning, seizures, sensory or perceptual changes (auditory, gustatory, kinesthetic, olfactory, tactile, visual), trauma
- Circumstances of present situation that might lead to injury
- Neurologic status, including level of consciousness, mental status, orientation
- Laboratory studies, including clotting factors, hemoglobin and hematocrit, platelet count, white blood cell count

Risk factors

- Ventilator alarms turned off
- Immobile patient incorrectly positioned on abdomen
- Pillows placed incorrectly under the head of patient who has a compromised airway
- Ventilator connections improperly monitored

Associated medical diagnoses (selected)

Acute respiratory failure, chronic obstructive pulmonary disease, drug overdose, inhalation injuries, multisystem trauma, near-drowning episode, sedation or placement under general anesthesia

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient's airway remains patent at all times. (1,2,3,4,5,6,7)
- Patient's vital signs remain within normal parameters. (3)
- Patient and family or significant other demonstrate knowledge of safety measures to prevent suffocation. (8)

Interventions and rationales

1. Monitor and record respiratory status. *Changes in respiratory rate and depth, cough, sputum production, and skin color may indicate airway obstruction.*
2. Monitor and record neurologic status. *Signs and symptoms of hypoxia include headache, depression, apathy, memory loss, poor muscular coordination, fatigue, stupor, and loss of consciousness.*
3. Monitor vital signs and report changes. *Hypoxia induces tachycardia and a slight rise in blood pressure. Advanced hypoxia reduces heart rate and causes loss of consciousness.*
4. Position patient on side or position head and neck to prevent relaxed neck muscles from obstructing the airway. *This allows maxi-*

mal chest expansion and prevents aspiration and airway obstruction.

5. Check all ventilator connections every 30 minutes if the patient is receiving mechanical ventilation *to ensure the patient receives proper amount of O₂ at appropriate volume and rate.*

6. Check ventilator alarms every 30 minutes and after suctioning *to ensure proper alarm function.*

7. Suction airway as needed *to prevent secretion accumulation. Do this only as needed, to prevent tracheal irritation.*

8. Provide patient and family or significant other with information about safety practices *to enable patient and significant other to take active role in care and ensure performance of safety measures.*

Documentation

- Patient's statements that indicate potential for injury
- Physical findings
- Observations or knowledge of unsafe practices
- Interventions performed to prevent injury

- Patient's response to nursing interventions
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

Definition

*Accentuated risk of accidental suffocation
(inadequate air available for inhalation)*

Assessment

- Health history, including accidents, allergies, exposure to pollutants, falls, hyperthermia, hypothermia, poisoning, seizures, sensory or perceptual changes (auditory, gustatory, kinesthetic, olfactory, tactile, visual), trauma
- Circumstances of present situation that might lead to injury
- Neurologic status, including level of consciousness, mental status, orientation
- Laboratory studies, including clotting factors, hemoglobin and hematocrit, platelet count, white blood cell count

Risk factors

Cognitive or emotional difficulties, injury or disease process, lack of safety education, lack of safety precautions, reduced motor abilities, reduced olfactory sensation

Associated medical diagnoses (selected)

Multisystem trauma, sedation, or placement under general anesthesia

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient avoids accidental suffocation. (1,2,3,4,5,6,7)
- Patient's vital signs remain within normal parameters. (4)
- Patient and family or significant other demonstrate knowledge of safety measures to prevent suffocation. (8)

Interventions and rationales

1. Observe, record, and report falls, seizures, and unsafe practices *to ensure implementation of appropriate interventions.*
2. Monitor and record respiratory status. *Changes in parameters (such as respiratory rate, cough, sputum production, skin color) may indicate airway obstruction.*
3. Monitor and record neurologic status. *Symptoms of hypoxia include headache, depression, apathy, memory loss, poor muscular coordination, fatigue, stupor, loss of consciousness.*
4. Monitor vital signs and report changes. *Hypoxic changes include tachycardia and slight rise in blood pressure. Advanced hypoxia re-*

duces heart rate and causes loss of consciousness.

5. Position patient on side or position head and neck to prevent relaxed neck muscles from obstructing the airway. *This allows maximal chest expansion and prevents aspiration and airway obstruction.*

6. Obtain suction equipment, assemble, and keep at the bedside *to assure equipment readiness in case of need.*

7. Suction as needed *to keep upper and lower airways clear and to stimulate cough reflex to enhance sputum removal. Do this only as needed, to prevent tracheal irritation.*

8. Provide patient and significant other with information about safety practices, *to enable patient and significant other to take an active role in care and ensure performance of safety measures.*

Documentation

- Patient's statements about the situation that indicate potential for injury
- Physical findings
- Record of falls, seizures, and unsafe practices

- Interventions that reduce risk of injury
- Patient's response to nursing interventions
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

Definition

Inability to move food, fluid, or saliva from the mouth through the esophagus

Assessment

- History of neuromuscular, cerebral, or respiratory disease
- Age
- Sex
- Nutritional status, including appetite, dietary intake, hydration, current weight, and change from normal weight
- Neurologic status, including barium swallow; chest X-ray; cognition; esophageal video fluoroscopy; gag reflex; level of consciousness; memory; motor ability; orientation; symmetry of face, mouth, and neck; sensory function; tongue movement

Defining characteristics

- Evidence of aspiration
- Observed evidence of difficulty in swallowing, including choking, coughing, stasis of food in oral cavity

Associated medical diagnoses (selected)

Bell's palsy, cerebrovascular accident, head injury, laryngectomy, maxillofacial trauma, tracheostomy

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient shows no evidence of aspiration pneumonia. (1,2,3)
- Patient achieves adequate nutritional intake. (4,5,6,7,8,9,10)
- Patient maintains weight. (4)
- Patient maintains oral hygiene. (7,8,9,10)
- Patient and family or significant other demonstrate correct eating or feeding techniques to maximize swallowing. (11,12)

Interventions and rationales

1. Elevate head of bed 90 degrees during mealtimes and for 30 minutes after completion of meal *to decrease risk of aspiration.*
2. Position patient on side when recumbent *to decrease risk of aspiration.*
3. Keep suction apparatus at bedside; observe and report instances of cyanosis, dyspnea, or choking. *Symptoms indicate presence of material in lungs.*
4. Monitor intake and output and weight daily until stabilized. Establish intake goal—for example, “patient consumes _____ ml of fluid; _____% of solid food.” Record and report any deviation from this. *Evaluating calorie and*

protein intake daily allows any necessary modifications to begin quickly.

5. Consult with dietitian to modify patient's diet, and conduct calorie count as needed *to establish nutritional requirements.*
6. Consult with dysphagia rehabilitation team, if available, *to obtain expert advice.* ‡
7. Provide mouth care three times daily *to promote comfort and enhance appetite.*
8. Keep oral mucous membrane moist by frequent rinses; use bulb syringe or suction, if necessary, *to promote comfort.*
9. Lubricate patient's lips *to prevent cracking and blisters.*
10. Encourage patient to wear properly fitted dentures *to enhance chewing ability.*
11. Serve food in attractive surroundings; encourage patient to smell and look at food. Remove soiled equipment, control smells, and provide a quiet atmosphere for eating. *A pleasant atmosphere stimulates appetite; food aroma stimulates salivation.*
12. Instruct patient and family in positioning; dietary requirements; specific feeding techniques, including facial exercises (whistling, etc.); using a short straw to provide sensory

stimulation to lips; tipping head forward to decrease aspiration; applying pressure above lip to stimulate mouth closure and swallowing reflex; checking oral cavity frequently for food particles (remove if present). *These measures allow patient to take an active role in maintaining health.*

Documentation

- Patient's expressions of feelings about current situation
- Observations of weight, swallowing ability, intake and output, oral hygiene
- Patient's response to nursing interventions
- Instructions about diet monitoring and feeding techniques
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Definition

Fluctuations in body temperature caused by thermoregulatory disturbances

Assessment

- History of present illness
- Medication history
- Neurologic status, including level of consciousness, mental status, motor status, sensory status
- Cardiovascular status, including blood pressure, capillary refill, electrocardiogram, heart rate and rhythm, pulses (apical and peripheral), temperature
- Respiratory status, including arterial blood gas measurements; breath sounds; and rate, depth, and character of respirations
- Integumentary status, including color, temperature, turgor
- Fluid and electrolyte status, including blood urea nitrogen, intake and output, serum electrolytes, urine specific gravity

- Laboratory studies, including clotting factors, hemoglobin and hematocrit, platelet count, white blood cell count

Defining characteristics

- Fever or hypothermic condition is refractory to antipyretic therapy
- Fluctuations in body temperature above or below the normal range
- Flushed or mottled skin
- Increased or decreased respiratory and heart rates
- Mild to severe dehydration
- Possible seizures or convulsions
- Skin warm or cool to touch

Associated medical diagnoses (selected)

Brain tumor, especially if located in hypothalamus, pituitary or medulla; burns; central nervous system dysfunction related to head trauma via surgery or injury; cerebral edema; cerebral hemorrhage; cerebrovascular accident; chemical toxicity (including pharmacologic or anesthesia reaction); congestive heart failure; dehydration; head injury; heat stroke; herniation syndrome; near-drowning; smoke inhalation or other anoxic events; temperature regulation affected by diseases causing pathologic changes in blood flow (Buerger's disease, congestive heart failure, diseases of hypothalamus and medulla, encephalitis, Raynaud's disease); untreated infection

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient maintains body temperature at normothermic levels. (1,2,3,4,5,6,7,8,9)
- Patient demonstrates no signs of shivering. (1,2,3,4,5,6,7,8)
- Patient expresses feelings of comfort. (1,4,5,6,7,8)
- Patient has warm, dry skin. (1,2,3,4,5,6,7,8)
- Patient maintains heart rate and blood pressure within normal range. (1,2,3,4,5,6,7,8)
- Patient exhibits no signs of compromised neurologic status. (1,2,3,6,8)
- Patient and family or significant other voice an understanding of the health problem. (8)

Interventions and rationales

1. Monitor body temperature every 4 hours, more often if indicated. Record temperature and route. *Monitoring determines effectiveness of therapy or if intervention is required, and facilitates accurate comparison of data. (Baseline normals vary with route.)*
2. Monitor and record neurologic status every 8 hours. Report any changes to physician. *Changes in level of consciousness can result from tissue hypoxia related to altered tissue*

perfusion. Hyperthermia increases cerebral edema and thus intracranial pressure; hypothermia depresses metabolic rate.

3. Monitor and record heart rate and rhythm, blood pressure, and respiratory rate every 4 hours. *Hyperthermia may create hypoxia by increasing oxygen demand, which results from increased tissue metabolism (metabolism increases 7% with each 1° F increase). This also means faster breathing and rising pulse rate.*

4. Administer analgesics, antipyretics, and medications that prevent shivering, as indicated. Monitor effectiveness and record. *Antipyretics help reduce fever. Shivering tends to retard lowering of body temperature. ‡*

5. Employ measures to reduce excessive fever when present:

- a. Remove blankets; place loincloth over patient.
- b. Apply ice bags to axilla and groin.
- c. Initiate tepid water sponge bath.
- d. Use cooling blanket if temperature rises above _____. Cool patient to _____ . ‡

6. Maintain hydration:

- a. Monitor intake and output.

- b. Administer parenteral fluids as ordered. ‡
- c. Determine patient's fluid preference. Keep oral fluids at bedside and encourage patient to drink. *These measures help maintain fluid balance. Keeping fluid preferences at bedside allows patient to actively participate in prescribed treatment.*

7. Maintain environmental temperature at a comfortable setting:

- a. Ensure that all metal and plastic surfaces that come into contact with patient's body are covered.
- b. Use warm blankets.
- c. Ensure that linen and clothing are clean and dry. *Temperature of external environment affects ease of body temperature regulation.*

8. Instruct patient and family or significant other regarding:

- a. signs and symptoms of altered body temperature
- b. precautionary measures to avoid hypothermia or hyperthermia
- c. adherence to other aspects of health

(continued)

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Interventions and rationales (continued)

care management to help normalize temperature (dietary habits, measures to prevent increased intracranial pressure, etc.)

- d. Rationale for treatment. *These measures allow patient to take active role in health maintenance.*

Documentation

- Patient's needs and perceptions of current problem
- Physical findings
- Intake and output
- Patient's response to nursing interventions
- Evaluations for each expected outcome.

Care plan notes

Care plan notes

Definition

Inability to process thoughts accurately and correctly

Assessment

- History of neurologic disorder, head injury, or psychiatric disorder
- Neurologic status, including cognition, insight and judgment, memory, motor ability, orientation, sensory ability
- Self-care status, including ability to perform activities of daily living; safety practices
- Psychosocial status, including coping mechanisms, family or significant other, occupation, personality, stressors (finances, job, marital discord)

Defining characteristics

- Altered attention span
- Clinical evidence of impaired neurologic or psychiatric functioning
- Decreased ability to grasp ideas
- Disorientation to time, place, person, circumstances, and events
- Impaired ability to abstract or conceptualize
- Impaired ability to calculate
- Impaired ability to make decisions
- Impaired ability to reason
- Impaired ability to solve problems
- Inability to follow instructions
- Inappropriate social behavior
- Memory deficit or problems

Associated medical diagnoses (selected)

Alzheimer's disease, anoxic encephalopathy, anxiety states, cerebrovascular accident, head injury, Korsakoff's psychosis, organic brain syndrome, psychiatric disorders

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient maintains orientation to time, place, and person. (3,5)
- Patient sustains no harm or injury. (1,4,7)
- Patient maintains current health status. (1,2)
- Patient and family or significant other voice feelings and concerns. (6,8,11)
- Family or significant other communicates an understanding of care required by patient. (6,7,10)
- Family or significant other demonstrates appropriate coping skills. (6,9,11)
- Family or significant other identifies available health resources. (11)

Interventions and rationales

1. Observe patient's thought processes every shift. Document and report any changes. *Changes may indicate progressive improvement or decline in underlying condition.*
2. Perform prescribed treatment for underlying condition; monitor progress. Report any favorable or adverse responses to treatment, *to assess effectiveness of treatment.*
3. Orient patient to reality as needed.
 - a. Call patient by name.

- b. Tell patient your name.
- c. Provide background information (place, time, date) frequently throughout the day, verbally and visually, using a reality orientation board.
- d. Orient patient to environment, including sights, sounds, and smells. *Reality orientation techniques foster patient's awareness of self and environment.*
- e. Keep items in the same places. *Consistent, stable environment reduces confusion, decreases frustration, and aids successful completion of activities of daily living.*
- f. Use TV or radio purposefully to augment orientation. *Reality orientation techniques foster patient's awareness of self and environment.*
- g. Ask family or significant other to provide patient with photos (labeled with name and relationship on back), favorite belongings, cards. *Belongings promote sense of continuity and memory, and create sense of security and comfort.*
- h. Protect from sensory overload; allow rest periods. *Sensory overload may increase*

disability; frequent rest periods help avoid fatigue.

4. Provide structured environment for patient. List daily routine and post in patient's room. Communicate patient's skill level to all personnel *to provide continuity and preserve level of independent functioning.*
5. Spend time daily with patient to encourage memories and discussion of past events. Encourage patient's participation in reminiscence groups. *Remote memory may be intact. Discussion of past events promotes sense of continuity, aids memory, and promotes feelings of security. Joining in reminiscence groups provides diversional activity and may increase socialization skills.*
6. Correct patient privately for inappropriate behavior; walk patient to room or initiate another behavior. *This avoids feelings of embarrassment and frustration. Redirection and engagement in previously successful activities increase patient's sense of accomplishment and reinforce desirable behavior.*
7. Provide close supervision to prevent patient from wandering off or incurring harm. Instruct

(continued)

† Numbers following outcomes refer to interventions.

Interventions and rationales (continued)

family or significant other on how to maintain a safe home environment for patient. *Patient may be unable to consider own safety needs or risks.* Place patient's photo or name on door to room, *to aid memory and help patient find room.*

8. Encourage patient to voice feelings and concerns about loss of memory. *This helps reduce anxiety and ventilate frustrations, and promotes acceptance of need for supervision and treatment regimen.*

9. Help family or significant other develop the necessary coping skills to deal with patient. *These are needed to deal with patient's neurologic or psychiatric impairment and the potential for deterioration in the patient's condition.*

10. Demonstrate reorientation techniques to family or significant other and provide time for supervised return demonstrations. *Informed family or significant other will be better pre-*

pared to cope with patient with altered thought processes.

11. Help family identify (or refer family to) community support group (stroke club, Alzheimer's group, etc.) *to assist in coping with the effects of illness.*

Documentation

- Patient's and family's or significant other's expression of concern and feelings about patient's altered thought processes
- Observations of patient's altered thought processes and response to treatment for underlying condition
- Patient's response to nursing interventions
- Instructions to family or significant other; their understanding of instructions and demonstrated ability to care for patient
- Referrals made for the patient and family or significant other
- Evaluations for each expected outcome.

Care plan notes

Care plan notes

Definition

Inability to process thoughts accurately and correctly

Assessment

- Reason for hospitalization
- Mental status, including abstract thinking (ask patient to interpret a proverb); general information (ask patient to name five states); insight concerning the present situation; judgment (ask patient to solve a simple problem); memory for recent and remote past; orientation to person, time, and place
- Neurologic status, including level of consciousness, motor ability, sensory ability
- Sleep habits
- Ability to perform activities of daily living
- Safety hazards
- Medication history
- Dietary and nutritional status
- History of alcohol consumption

Defining characteristics

- Altered attention span
- Altered sleep patterns
- Changes in remote, recent, or immediate memory
- Cognitive dissonance
- Confabulation
- Decreased ability to grasp ideas
- Delusions
- Disorientation in time, place, person, circumstances, or events
- Distractibility
- Hallucinations
- Impaired ability to make decisions
- Impaired ability to reason, abstract, or conceptualize
- Impaired ability to solve problems
- Inaccurate interpretation of the environment
- Inappropriate affect
- Inappropriate social behavior
- Presence of a physiologic cause for altered thought processes

- Verbal report of limitations on usual thought processes

Associated medical diagnoses (selected)

Brain tumor; diabetic ketoacidosis; drug or alcohol withdrawal; drug intoxication; head trauma; hypoxemia or hypercarbia of acute respiratory failure; malnutrition; sensory deprivation from isolation, prolonged bed rest, or traction; septicemia

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient remains safe and protected from injury. (1,4,7,8,11)
- Patient maintains awareness of the need for assistance. (4,5,7,11)
- Patient maintains orientation to person, time, and place. (2,3,6,7,9,13)
- Patient performs activities of daily living with assistance. (10,11,12)
- Laboratory values stay within normal range. (1)
- Physiologic causes receive treatment, resulting in restoration of thought processes. (2)
- Family or significant other identifies partial or complete confusion. (13,14,15)
- Family or significant other makes arrangements for home care. (16)

Interventions and rationales

1. Monitor the following and record: vital signs every 4 hours; neurologic signs every shift; laboratory values daily (blood glucose and alcohol, arterial blood gases, electrolytes). *Vital signs assess patient for signs and symptoms of infection or complication. Neurologic assessment and laboratory studies may reveal*

progressive improvement or decline of underlying condition.

2. Carry out medical regimen to treat underlying causes of mental status deterioration.

Medical regimen aims to alleviate causes of mental status deterioration. ‡

3. Address patient by name. Tell patient your name. *Reality orientation techniques foster patient's awareness of self and environment.*

4. Give short, simple explanations to patient each time you do something, *to avoid confusion and aid successful task completion.*

5. Schedule nursing care to provide quiet times. *Rest periods help avoid sensory overload.*

6. Mention time, place, and date frequently throughout the day. Have a clock and a calendar where patient can easily see them; refer to these aids when orienting patient. *Reality orientation techniques foster patient's awareness of self and environment.*

7. Keep patient's things in the same places to the extent possible. *A consistent, stable environment reduces confusion and frustration, and aids successful completion of activities of daily living.*

8. Use appropriate safety measures to protect patient from injury. Avoid physical restraints if possible. *Patient may be unable to consider own safety needs or risks. Restraints may agitate patient.*

9. Ask family or significant other to bring photos (label with name and relationship on back), favorite articles, and cards. *Familiar items help create a more secure environment for patient.*

10. Plan patient's routine and be as consistent as possible in following it. *A consistent daily plan aids task completion, and reduces confusion and frustration.*

11. Speak slowly and clearly. Allow ample time for patient to respond. *This reduces confusion and frustration, and aids task completion.*

12. Encourage patient to perform activities of daily living. Be patient and specific in providing instructions. Allow time for patient to perform each task. *This enhances patient's self-esteem and helps prevent complications of inactivity. New skills or tasks should be limited to small, critical units to aid learning. Patient*

(continued)

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Interventions and rationales (continued)

may need extensive supervision and repetition to master new tasks.

13. Encourage family or significant other to share stories and discuss familiar things with patient. *Remote memory often remains intact. Sharing stories and familiar things promotes sense of continuity, aids memory, and creates a sense of security and comfort.*

14. Support family or significant other in attempts to interact with patient. *Family or significant others need positive reinforcement for visiting and attempting to interact with patient.*

15. Allow time before and after visits for spouse or significant other to express feelings. *Expression of feelings in a supportive environment is important in helping spouse or significant other cope with patient's illness.*

16. Refer family or significant other to appropriate resources to plan for patient care after discharge. *This helps provide a comprehensive approach to post-discharge care.*

Documentation

- Patient's verbal responses
- Observations of patient's behavior indicative of altered thought processes
- Interventions that focus on helping patient maintain reality orientation
- Responses of patient to nursing interventions
- Evaluations for each expected outcome.

Care plan notes

Care plan notes

Definition

Damage to mucous membranes or to corneal, integumentary, or subcutaneous tissue

Assessment

- History of peripheral vascular disease or surgery
- Age
- Sex
- Integumentary status, including color, skin care practices, temperature, tenderness, texture, turgor, edema
- Cardiovascular status, including blood pressure, cardiac output, occupation, patient and family history of cardiovascular disease, peripheral pulses, smoking history
- Nutritional status, including dietary patterns, laboratory tests, serum lipids level, serum protein level, weight change from normal
- Neurologic status, including motor function, sensory pattern

Defining characteristics

- Arterial insufficiency, including bruits, coolness, cyanosis or mottling; decreased or absent peripheral pulses; delayed capillary filling; exertional limb pain relieved with rest; loss of hair on limbs; pallor on elevation of limbs; redness (rubor) on lowering of limbs; sensitivity to cold; thin, tight, shiny skin; thickened, brittle nails; ulceration on extremity
- Venous insufficiency, including atrophy of skin and soft tissue; coldness and pallor of extremities; edema of lower extremities; gangrenous changes; leg pain during menstruation; nocturnal cramping; swollen, ropelike, or ruptured superficial leg veins
- Neurologic changes, including paresis, paresthesias

Associated medical diagnoses (selected)

Buerger's disease (thromboangiitis obliterans), chronic or acute arterial insufficiency, pregnancy, Raynaud's phenomenon, venous insufficiency or venous stasis

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes [†]

- Patient attains relief from immediate symptoms (pain, ulcers, color changes, edema). (1,4,5,6,7)
- Patient maintains collateral circulation. (2,3)
- Patient voices intent to stop smoking. (4)
- Patient voices intent to follow specific management routines after discharge. (1,2,3,4,5,6,7)

Interventions and rationales

1. Provide scrupulous foot care. Administer and monitor treatments according to institutional protocols. *Foot care prevents fungal infections and ingrown toenails, stimulates circulation, and promotes awareness of signs and symptoms that should be reported to doctor immediately.* ‡
2. Instruct patient to avoid pressure on popliteal space. For example, say "Do not cross your legs or wear constrictive clothing." *This avoids reducing arterial blood supply and increasing venous congestion.*
3. Encourage adherence to exercise regimen as tolerated. *Exercise improves arterial circu-*

lation and venous return by promoting muscle contraction-relaxation.

4. Educate patient about risk factors and prevention of injury. Refer patient to smoking cessation program. *Teaching about factors influencing peripheral vascular disease and prevention of tissue damage helps prevent complications.*

5. Maintain adequate hydration. Monitor intake and output; record daily weights. *Adequate hydration reduces blood viscosity and decreases risk of clot formation.*

6. With venous insufficiency, apply antiembolism stockings or intermittent pneumatic compression stockings, removing them for 1 hour every 8 hours or according to institutional protocol. Elevate patient's feet when sitting and elevate foot of bed 6" to 8" when lying down. *These measures promote venous return and decrease venous congestion in lower extremities.* ‡

7. With arterial insufficiency, elevate head of bed 6" to 8" when lying down. *This increases arterial blood supply to extremities.*

Documentation

- Patient's expressions of feelings about current situation
- Observations of skin color, turgor, temperature, ulcer size
- Patient's response to nursing interventions
- Evaluations for each expected outcome.

Care plan notes

[†] Numbers following outcomes refer to interventions.

[‡] Indicates doctor-ordered instruction.

Tissue integrity impairment

related to physical, chemical,
or electrical hazards during surgery

163a

Definition

Damage to mucous membranes or to corneal, integumentary, or subcutaneous tissue

Assessment

- Reason for surgery
- Type of surgery
- Anticipated length of surgery
- Health status, including age, sex, weight, vital signs, temperature, nutritional status, integumentary status, cardiovascular status, neurologic status, respiratory status, psychosocial status
- Mobility status, including range of motion
- Patient's description of pain, numbness, tingling
- Laboratory studies, including hematocrit and hemoglobin, complete blood count, blood coagulation studies, immunologic and serologic tests, electrolytes, urinalysis, liver function tests, serum protein levels
- Wound classification (clean, clean-contami-

nated, contaminated, dirty)

- Allergies to medications, irrigation solutions, cleansing solutions
- Health history, including altered immunologic status, malnutrition, chronic metabolic or systemic disease (diabetes mellitus; cancer; cardiovascular, renal, or hepatic diseases; coagulation disorders; blood dyscrasias; or hematopoietic diseases)
- Current medical treatments, including radiation therapy, chemotherapy, steroid therapy, immunosuppressive therapy, anticoagulant or thrombolytic therapy, antibiotic therapy
- Presence of infection, draining wounds, bruises, shear ulcers, pressure ulcers

Defining characteristics

- Blisters or blebs
- Discoloration
- Disrupted tissue
- Edema
- Erythema

- Eschar
- Exudate
- Itching
- Odor
- Pain

Associated medical diagnoses (selected)

Acquired immunodeficiency syndrome; alcoholism; anemia; cancer; cardiovascular disease; dermatitis; diabetes mellitus; infection; leukemia; liver cirrhosis; neurologic disorders affecting sensory-motor function; obesity; respiratory disease; skin lesions

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient expresses feelings of comfort. (1,3,4,5)
- Patient remains free from alteration in tissue integrity related to physical hazards. (1,2,4,5,6,7,8,14)
- Patient remains free from alteration in tissue integrity related to chemical hazards. (1,2,9,10,11,12,13,15,16,17,18)
- Patient remains free from alteration in tissue integrity related to electrical hazards. (1,2,19,20,21)

Interventions and rationales

1. Document and report results of preoperative nursing assessment. Identify factors that predispose patient to impaired tissue integrity. *A complete nursing assessment allows for development of an individualized care plan.*
2. Classify the surgical wound according to the degree of contamination of wound and surrounding tissue. *Classifying the surgical wound facilitates assessment of risk of wound infection and subsequent tissue injury.*
3. Use padding, special mattresses, and support devices during surgery. *These measures*

reduce undue pressure and decrease risk of impaired tissue integrity.

4. Maintain environmental temperature at a comfortable setting. Offer blankets, if needed. *A comfortable environment reduces shivering, muscle tension, and reactive pain. These metabolic stressors can affect the rate of cellular repair.*
5. Monitor patient for signs of hypothermia (shivering, cool skin, pallor, piloerection, increased heart rate) *to determine the need to implement warming measures.*
6. Warm prepping and irrigation solutions *to prevent reduction in patient's temperature.*
7. For infants (age 1 year or less) use warming unit and head covering. *Infant thermoregulatory mechanisms are immature and do not retain adequate body heat.*
8. When using pneumatic tourniquets, pad skin, place cuff so skin is free of wrinkles, set to proper pressure, and monitor inflation time. *Improper tourniquet use can impair circulatory status of affected limb.*
9. Check patient history for sensitivity or allergy to prepping solution. Clean and prepare skin incision site with nonirritating solutions.

Nonallergenic, physiologic prepping and cleansing solutions reduce risk of tissue reaction and injury.

10. To avoid pooling of solutions, use towels or pads during prep. When using sprays, shield patient's face and eyes. *Pooled solutions can produce skin maceration. Sprays may damage cornea and mucous membranes.*
11. Ensure adequate aeration of items sterilized by ethylene oxide gas. *Residual gas is toxic to tissue.*
12. Rinse chemosterilized items adequately. *Residual chemosterilization solutions are toxic to tissue.*
13. Remove powder from gloves. *Glove powder may cause granulomas and other reactions.*
14. Perform sponge, sharp, and instrument counts according to protocol; account for other items (bulldogs, umbilical tapes, vessel loops); and document results. *Retained objects may produce foreign body reaction or injury to tissue.*
15. Follow manufacturer's instructions for applying medications and chemical agents such

(continued)

† Numbers following outcomes refer to interventions.

Interventions and rationales (continued)

as glutaraldehyde and methylmethacrylate.

Agents may be toxic when applied directly to tissue. ‡

16. Use physiologic solutions or prescribed medications for irrigation or topical application. *Nonphysiologic solutions may cause interstitial edema and cellular injury or death.*

17. Check label, route, dose, and expiration date of each medication with scrub nurse *to reduce risk of error. ‡*

18. When administering medications, record drug, dosage, and route. Document verbal orders and have physician cosign. *Documentation helps to reduce medication errors. ‡*

19. Inspect all electrical, mechanical, and air-powered equipment before use. Operate equipment according to manufacturers' instruction *to reduce chances of patient injury.*

20. Apply electrosurgical dispersive pad to clean, dry skin near operative site. Avoid bony prominences, hairy surfaces, scar tissue, or

areas of poor circulation. *Proper placement reduces risk of burn injury.*

21. When using hypothermia or hyperthermia blanket avoid creases, place sheet between skin and blanket, set and maintain correct temperature. Pad extremities during hypothermia therapy. *Proper use protects against tissue injury.*

Documentation

- Results of preoperative nursing assessment
- Surgical procedure
- Type of anesthesia
- Preoperative and postoperative diagnosis
- Wound classification
- Preexisting conditions that increase risk of tissue injury
- Nursing interventions performed to protect tissue integrity
- Medications administered
- Patient's status on discharge to post anesthesia care unit

- Skin condition on discharge to post anesthesia care unit
- Presence of lines, tubes, catheters, and drains
- Type of wound closure and dressing
- Evaluations for each expected outcome.

Care plan notes

‡ Indicates doctor-ordered instruction.

Care plan notes

Definition

Damage to mucous membranes or to corneal, integumentary, or subcutaneous tissue

Assessment

- History of radiation therapy or exposure
- Age
- Sex
- Integumentary status, including color, distribution of hair, mucous membranes, skin care practices, temperature, tenderness, texture, turgor, scars, lesions, wounds
- Nutritional status, including dietary patterns, weight change from normal

Defining characteristics

- Skin: blistered, dry, edemic, hairless, pruritic, moist, reddened, scaling, ulcerated, warm

Associated medical diagnoses (selected)

Radiation exposure occurring during cancer or keloid reduction therapy or accidental radiation exposure

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes [†]

- Irritation and breakdown of irradiated areas avoided. (1,2,3,4,5,6,7,8,9,10,12)
- Ulcerated areas healed. (1,2,3,4,6,9,10,11,12)
- Patient maintains adequate fluid and nutritional intake. (13,14)
- Patient and family or significant other communicate understanding of skin care regimen, medication use, and need for adequate fluid and nutritional intake. (15)

Interventions and rationales

1. Keep skin clean, dry, and exposed to air as much as possible *to promote healing of excoriated areas and prevent infection.*
2. Avoid constrictive clothing *to reduce risk of friction and decreased blood flow.* Avoid exposure to sun *to reduce risk of sunburn and possible skin cancer.*
3. Avoid nonprescribed ointments, creams, and warm packs *because they may increase skin irritation and possible radiation (if they contain heavy metals).*
4. Avoid extremes of hot and cold on affected

skin areas *to prevent further irritation and skin breakdown.*

5. Avoid vigorous scrubbing of irradiated areas *to minimize skin breakdown.*

6. Use nonadhesive dressings *to avoid pulling on affected skin.*

7. Provide oral hygiene as indicated *to promote comfort and reduce risk of infection.* Use soft toothbrush *to reduce risk of bleeding.*

8. Use cornstarch over unbroken areas *to decrease itching and friction.*

9. Provide regular change of position, bed cradle, or pressure-relieving devices, when indicated. *These measures reduce friction and risk of skin breakdown on affected body parts.*

10. Inspect skin every shift. Report areas of breakdown and signs of infection *to ensure early treatment.*

11. Follow institutional protocol for treating infected lesions. Administer creams, antibiotic ointments, and irrigation solutions, as ordered, and monitor effectiveness. *Protocols are established to meet specific patient needs.* [‡]

12. Administer analgesics as ordered, and monitor effectiveness. *Analgesics reduce pain resulting from skin problems.* [‡]

13. Consult dietitian to assist with diet, emphasizing high protein, calories, vitamins, and minerals to promote tissue repair and prevent catabolism. *Positive nitrogen balance promotes wound healing.*

14. Administer antiemetics as ordered *to promote patient comfort and adequate nutrition.* Monitor effectiveness. [‡]

15. Educate family and patient in skin care regimen, medication administration, and nutritional needs *to promote compliance and maintain tissue integrity.*

Documentation

- Patient's expression of feelings
- Physical findings
- Interventions performed to prevent irritation or breakdown or to promote healing
- Patient's response to nursing interventions
- Patient's and family's or significant other's response to education
- Evaluations for each expected outcome.

[†] Numbers following outcomes refer to interventions.

[‡] Indicates doctor-ordered instruction.

Tissue perfusion alteration (cardiopulmonary)

related to decreased cellular exchange

165

Definition

Decrease in cellular nutrition and respiration caused by decreased capillary blood flow

Assessment

- Health history, including presence of diabetes mellitus, high cholesterol, hypertension, obesity, smoking, stressful life-style, family history of heart disease
- Neurologic status, including level of consciousness, mental status, orientation
- Cardiovascular status, including blood pressure; heart rate and rhythm; heart sounds; peripheral pulses; skin color, temperature, and turgor; hepatojugular reflux; jugular vein distention; history of congenital heart disease or valvular disorder
- Diagnostic tests, including chest X-ray, ECG, exercise ECG, echocardiogram, nuclear isotope studies, cardiac angiography
- Respiratory status, including arterial blood gas levels, auscultation of breath sounds,

respiratory rate and depth

- Renal status, including intake and output, urine specific gravity, weight
- Integumentary status, including cyanosis, pallor, peripheral edema

Defining characteristics

- Arrhythmias; ECG changes
- Abnormal arterial blood gas levels
- Chest pain with or without activity
- Cold, clammy skin
- Crackles
- Cyanosis
- Decreased or absent urine output
- Decreased peripheral pulses
- Elevated cardiac enzymes and isoenzymes
- Fatigue
- Hypotension
- Mental status changes
- Pallor of skin and mucous membranes
- Palpitations
- Edema

- Rhonchi
- Shortness of breath
- Slow capillary refill time
- Tachycardia
- Variations in hemodynamic readings

Associated medical diagnoses (selected)

Adult respiratory distress syndrome, anaphylactic shock, anemia, aortic stenosis or insufficiency, arteriosclerotic heart disease, cardiac tamponade, cardiogenic shock, chronic obstructive pulmonary disease (COPD), congestive heart failure, coronary artery spasm, hypovolemic shock, lung abscess, mitral stenosis or insufficiency, neurogenic shock, pericarditis, pneumonia, pulmonary artery infarct, pulmonary emboli, respiratory failure, septic shock

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes†

- Patient attains hemodynamic stability. Pulse not less than _____ beats/minute and not greater than _____ beats/minute. Blood pressure not less than _____ mm Hg and not greater than _____ mm Hg. (1)
- Patient does not exhibit arrhythmias. (1,4)
- Skin remains warm and dry. (2)
- Heart rate remains within prescribed limits while patient carries out activities of daily living. (6,7,9)
- Patient maintains adequate cardiac output. (1,3,4,5,8)
- Patient modifies life-style to minimize risk of decreased tissue perfusion. (6,7,9)

Interventions and rationales

1. Monitor and document vital signs (heart rate, blood pressure, and central venous pressure) every hour until stable, then every 2 hours. Report any findings outside prescribed limits. *Decreased heart rate, central venous pressure, and blood pressure may indicate increased arteriovenous exchange, which leads to decreased tissue perfusion.*
2. Monitor skin color and temperature every

2 hours and assess for signs of skin breakdown. *Cool, blanched, mottled skin and cyanosis may indicate decreased tissue perfusion.*

3. Monitor respiratory rate and breath sounds. Document findings. *Increased respiratory rate may indicate that the patient is compensating for tissue hypoxia.*

4. Monitor ECG for changes in heart rate and rhythm. *Altered heart rate and rhythm may affect tissue perfusion and possibly indicate a life-threatening crisis.*

5. Maintain oxygen therapy, as ordered, to maximize oxygen exchange in alveoli and at cellular level.

6. Encourage patient to change position and participate in activity, as condition permits, to enhance vital capacity and avoid lung congestion and onset of skin breakdown.

7. Encourage frequent rest periods to conserve energy and maximize tissue perfusion.

8. Monitor creatine phosphokinase (CPK), lactic dehydrogenase (LDH), and arterial blood gas levels. *Abnormal findings may indicate tissue damage or decreased oxygen exchange in lungs.*

9. Inform patient about:
 - a. risk factors for heart and lung disease
 - b. proper use of nitroglycerin
 - c. proper use of medications and possible adverse reactions
 - d. the benefits of a low-fat, low-cholesterol diet
 - e. the need to avoid straining with bowel movements
 - f. the benefits of quitting smoking
- Effective teaching encourages patient to take an active role in health maintenance.*

Documentation

- Observations of physical findings
- Observation of patient's response to activity
- Verbal statements and behavior indicating patient's perception of health problems and health needs
- Nursing interventions performed and patient response
- Patient demonstration of skills associated with maintaining diet, adhering to medication regimen, maintaining activity level, and managing stress
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

Tissue perfusion alteration (cerebral)

related to decreased cellular exchange

166a

Definition

Decrease in cellular nutrition and respiration caused by decreased capillary blood flow

Assessment

- Vital signs
- History of the event including the presenting problem, history of development, chief complaint, associated vascular problems, associated psychosocial problems (which may contribute to behavioral changes)
- Neurologic status, including level of consciousness; Glasgow Coma Scale score (eye response, motor response, verbal response); orientation; pupil size; response to light and accommodation; motor activity; strength, positioning, and appearance of all four extremities; presence of reflexes (corneal, gag, swallowing, Babinski's); nuchal rigidity; weakness; numbness; headaches; dizziness; dysphagia; slurred speech; seizure activity; posturing; Cushing's Triad (increased systolic pressure,

decreased diastolic pressure, decreased heart rate)
• Respiratory status, including shallow or irregular breathing pattern

Defining characteristics

- Behavioral changes
- Change in level of consciousness
- Change in respiratory pattern
- Dizziness
- Dysphagia
- Eye deviation
- Headaches
- Impaired gag reflex
- Irritability
- Lethargy
- Memory loss
- Nausea and vomiting
- Orthostatic hypotension
- Photophobia
- Posturing
- Pupillary changes

- Restlessness
- Seizures
- Slurred speech
- Tinnitus
- Unilateral weakness or paralysis
- Visual changes

Associated medical diagnoses (selected)

Acute head injury, cerebral edema, acute meningitis, arteriovenous malformation, cerebral aneurysm, cerebrovascular accident, cerebral vasospasm, epidural hemorrhage, subtentorial herniation, subarachnoid hemorrhage, subdural hemorrhage, supratentorial herniation, supratentorial shift, transient ischemic attack, tumors, ventricular bleed

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient maintains or improves current level of consciousness. (1,2,3,4,5,6,7,8,9,12,13,15)
- Intracranial pressure remains between _____ mm Hg and _____ mm Hg. (2,3,4,6,9)
- Blood pressure remains high enough to maintain cerebral perfusion pressure but low enough to prevent increased bleeding or cerebral swelling. (2,3,4,6,9)
- Hypercarbia is prevented. (6)
- Patient is free from pain. (2,3,4,6,9)
- Patient stays in a quiet environment. (8)
- Patient performs activities of daily living with maximum level of mobility and independence. (10,11)
- Patient maintains balanced intake and output. (16)
- Risk factors for altered cerebral perfusion and complications are reduced as much as possible. (4,5,9,12,14,16,17,18)

Interventions and rationales

1. Conduct a neurologic assessment every 1 to 2 hours initially, then every 4 hours once the patient becomes stable, *to screen for*

changes in level of consciousness and neurologic status.

2. Take vital signs every 1 to 2 hours initially, then every 4 hours once the patient becomes stable, *to detect early signs of decreased cerebral perfusion pressure or increased intracranial pressure.*
3. Take patient's temperature at least every 4 hours. *Hyperthermia causes increased intracranial pressure; hypothermia causes decreased cerebral perfusion pressure.*
4. Elevate head of patient's bed 30 degrees *to prevent rise in intercerebral pressure and to facilitate venous drainage, thereby reducing cerebral edema.*
5. Keep head in neutral alignment *to keep carotid flow unobstructed, thereby facilitating perfusion.*
6. If patient's score on the Glasgow Coma Scale is less than 10, hyperventilate patient on a ventilator in accordance with hospital policy *to increase oxygenation and prevent cerebral swelling and hypercarbia.*
7. Monitor for Cushing's Triad, *which is a sign of impending herniation.*
8. Keep environment and patient quiet. Sedate

patient if necessary. Space nursing actions. *These measures reduce increased intracranial pressure.*

9. If the patient has a potentially compromised airway, use antiemetics or nasogastric suction *to prevent nausea and vomiting, which may lead to increased intracranial pressure and aspiration.*
10. Institute physical and occupational rehabilitation *to increase patient's ability for independent functioning.*
11. Prepare the patient's discharge plan *to make sure the patient receives necessary rehabilitative care postdischarge.*
12. Maintain adequate nutrition *to facilitate tissue healing, oxygenation, and metabolism.*
13. Maintain routine bowel and bladder function and administer diuretics such as mannitol, as ordered, *to prevent increased intracranial pressure.*
14. Monitor hematocrit and hemoglobin and report abnormalities *to prevent ischemia.*
15. Take measures to ward off infection *to prevent increased metabolic and oxygen*

(continued)

† Numbers following outcomes refer to interventions.

Tissue perfusion alteration (cerebral)

related to decreased cellular exchange

166b

Interventions and rationales (continued)

demands that can interfere with the brain's metabolic needs.

16. Measure accurate intake and output to prevent volume overload or deficit.

17. Instruct patient and family members in ways to minimize risk factors for altered tissue perfusion, to increase probability that healthy adaptation will continue.

18. Administer H₂-receptor antagonists, as ordered, to prevent the development of stress ulcers.

Documentation

- Observations of vital signs and neurologic findings
- Intake and output
- Patient's response to treatment of underlying condition
- Medications administered and patient response

- Nursing interventions performed and patient response
- Family response to education and nursing interventions
- Patient's response to physical and occupational therapy
- Evaluation of plan of care
- Evaluations for each expected outcome.

Care plan notes

Care plan notes

Tissue perfusion alteration (peripheral)

related to reduced arterial blood flow

168a

Definition

Decrease in cellular nutrition and respiration because of decreased capillary blood flow

Assessment

- History of vascular problems and disease (self or family)
- Age
- Sex
- Integumentary status, including color, condition of nails, distribution of hair, lesions, temperature, texture, edema
- Cardiovascular status, including blood pressure, capillary refill, clotting profile, Doppler studies, exercise test, heart rate and rhythm, pulses (brachial, femoral, pedal, peripheral, popliteal space, posterior tibial, radial), serum cholesterol level, triglyceride levels, venogram or arteriogram
- Neurovascular status, including activity tolerance, mobility, sensation

- Nutritional status, including dietary patterns, weight
- Psychosocial status, including alcohol intake, family support, history of smoking, occupation, stressors

Defining characteristics

- Anxiety
- Atrial arrhythmias
- Bruit(s)
- Clinical evidence of interruption or reduction in arterial blood flow
- Decreased mobility of joints
- Diminished or absent peripheral pulses
- Diminished sensitivity to pressure, temperature, tissue trauma
- Edema of extremities
- Intermittent claudication
- Irritability
- Muscle wasting or weakness
- Numbness, tingling
- Obesity

- Skin: blanched when extremity raised above level of heart, cool to touch, cyanotic with severe disease, gangrenous, glossy, hairless, pale, pruritic, slow-healing, trophic changes of skin and nails, ulcerated

Associated medical diagnoses (selected)

Acute: aortic aneurysm, atrial fibrillation, bacterial endocarditis, congestive heart failure, myocardial infarction

Chronic: Buerger's disease, diabetes mellitus, Leriche's syndrome, Raynaud's disease, Raynaud's phenomenon, rheumatoid arthritis, subclavian steal syndrome, systemic lupus erythematosus

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient expresses feeling of comfort or absence of pain at rest. (1,2,3,19)
- Arrhythmias avoided. (4)
- Peripheral pulses present and strong. (5,19)
- Skin color and temperature remain unchanged. (6,7,8,9)
- Feet remain clean and free from pressure areas. (10)
- Patient performs Buerger-Allen exercises. (11,12)
- Patient loses _____ lb(s)/week. (13,14,15,16)
- Prothrombin time is 35 to 60 seconds. (17,18)
- Patient practices relaxation techniques at least once every 8 hours. (20)
- Ulcerated areas heal. (21)
- Patient demonstrates ability to perform skills needed to follow prescribed care regimen. (22)
- Patient identifies risk factors that exacerbate the problem. (16,22)
- Patient maintains tissue perfusion and cellular oxygenation. (1,4,6,12,13)
- Patient reduces metabolic needs. (7,12,20)

Interventions and rationales

1. Elevate head of bed 30 degrees or place head of bed on 6" to 8" blocks *to promote circulation to lower extremities.*
2. Change patient's position every 2 hours, *to reduce risk of skin breakdown.*
3. Administer analgesics and monitor effectiveness, *to help reduce ischemic pain. Recording effectiveness guides further analgesic administration.‡*
4. Monitor vital signs and heart rhythm every 4 hours. Report development of rapid, irregular pulse. *Rapid, irregular pulse can cause decreased cardiac output, which results in decreased tissue perfusion.*
5. Check peripheral pulses every 4 hours. Document presence or absence and intensity of each. Use an ultrasonic blood flow detector if one is available. *Palpable, strong peripheral pulses indicate good arterial flow. Documentation reveals changes from one assessment to the next.*
6. Assess skin color, temperature, and texture at least every 4 hours. Note, record, and report development of mottling or black-and-blue areas. *Decreased tissue perfusion causes*

mottling; skin also becomes cooler and skin texture changes.

7. Do not apply direct heat to extremities. Heat may be applied to the abdomen; this causes reflex dilation of arteries of lower extremities. *Directly heating extremities causes increased tissue metabolism; if arteries do not dilate normally, tissue perfusion decreases and ischemia may occur.*
8. Use light cotton blankets to cover legs. *These provide insulation from cold but do not exert pressure on extremities.*
9. Use a bed cradle when patient has ulcerations or gangrene. *This helps prevent heavy sheets and blankets from resting on affected extremities.*
10. Provide meticulous foot care daily: soak patient's feet in warm water; trim nails carefully; rub feet with lanolin-based lotion; dry feet thoroughly; apply heel protectors; instruct patient to wear white cotton socks. *These measures prevent cracking of dry skin and other complications.*
11. Teach patient to perform Buerger-Allen exercises twice a day. Raise the affected ex-

(continued)

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Interventions and rationales (continued)

tremity above heart level; hold for 2 minutes. Lower the extremity to a dependent position, and hold for 3 minutes. Repeat. *These exercises aid collateral circulation to the legs.*

12. Encourage ambulation to level of tolerance, *to encourage circulation to the extremities.*

13. Provide a diet low in saturated fat, *to reduce risk of atherosclerosis, which further decreases circulation and tissue perfusion.* ‡

14. Reduce patient's caloric intake to promote weight reduction. *Extra weight can stress the heart and decrease circulation.* ‡

15. Help patient set goals for weight reduction. *This gives patient sense of control and provides motivation.*

16. Consult dietitian *to help patient modify eating patterns and habits.*

17. Administer anticoagulants, as ordered, to prevent thrombi. *Thrombi and emboli can fur-*

ther reduce arterial circulation and decrease tissue perfusion. ‡

18. Monitor clotting data, *to guide administration of anticoagulants.*

19. Administer vasodilators, alpha-blocking agents, and other medications, as ordered. Monitor effectiveness and document patient response. *These agents aid vessel dilation, which promotes increased circulation. They work only if vessels are capable of dilating.* ‡

20. Teach relaxation techniques, *to help improve vasodilation and help prevent vasoconstriction caused by anxiety.*

21. For patients with leg ulcers, follow the prescribed regimen. *Collaborative practice enhances overall patient care.* ‡

22. Educate patient about:

- foot care
- importance of exercise
- need for low-cholesterol, low-caloric diet
- need to avoid tight clothes, crossing of legs, and keeping legs dependent

e. need to avoid vasoconstrictors (cold, stress, smoking)

f. precautionary measures to prevent injury. *These measures enable the patient and family or significant other to join actively in care, and allow patient to make more informed decisions about health status.*

Documentation

- Patient's expressions of symptoms, such as pain, numbness, muscle weakness
- Observations of physical findings
- Nursing interventions performed for patient
- Patient's response to nursing interventions
- Patient's response to education
- Evaluations for each expected outcome.

Care plan notes

Tissue perfusion alteration (renal)

related to decreased cellular exchange

169

Definition

Decrease in cellular nutrition and respiration caused by decreased capillary blood flow

Assessment

- Health history, including surgery, any condition resulting in fluid volume depletion, or use of nephrotoxic drugs
- Renal status, including color of urine, intake and output, presence of anuria or oliguria, urine specific gravity, weight
- Cardiovascular status, including blood pressure, central venous pressure, hemodynamic readings, jugular filling, and presence of dependent edema, fluid retention, or palpitations
- Respiratory status, including auscultation of breath sounds, respiratory rate and rhythm, shortness of breath
- Neurologic status including level of consciousness, mental status, orientation, and evidence of decreased tolerance to activity, fatigue, weakness

- Integumentary status, including color, moisture, and presence of edema and secondary ulcerations from edema
- Nutritional status, including thirst, signs of anorexia
- Laboratory studies, including blood urea nitrogen (BUN), creatinine, creatinine clearance, hemoglobin, serum electrolytes, urine osmolality

Defining characteristics

- Abnormal serum electrolyte levels
- Dark, concentrated urine
- Decreased hemoglobin levels
- Decreased level of consciousness
- Decreased urine osmolality
- Decreased urine output
- Elevated BUN, creatinine and creatinine clearance levels
- Increased blood pressure
- Peripheral edema
- Shortness of breath

- Weakness
- Weight gain

Associated medical diagnoses (selected)

Acute: Acute renal failure, aortic aneurysm, disseminated intravascular coagulation (DIC), hemorrhage, myocardial infarction, renal calculi, shock, sickle cell crisis

Chronic: Chronic renal failure, diabetes mellitus, nephrotoxic drug poisoning, polycystic kidney disease

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient maintains fluid balance. (1,2,3,4,5)
- Patient maintains urine specific gravity within normal limits (specify). (6)
- Patient's weight does not fluctuate. (3)
- Patient reports increased comfort. (8,9,13)
- Patient maintains hemodynamic stability. (7)
- Patient identifies risk factors that exacerbate decreased tissue perfusion and modifies lifestyle appropriately. (10,11)
- Patient communicates understanding of medical regimen, medications, diet, and activity restrictions. (8,9,10,11,12,13)

Interventions and rationales

1. Monitor and document intake and output every 1 hour until output is greater than 30 ml/hour, then every 2 to 4 hours. *If the patient doesn't have a history of renal disease, urine output is a good indicator of tissue perfusion. Decreased or absent urine output usually indicates poor renal perfusion.*
2. Document urine color and characteristics. Report any changes. *Concentrated urine may indicate poor kidney function or dehydration.*
3. Monitor and document weight daily (before

breakfast). *Weighing patient helps predict overall fluid status. Weight gain may indicate fluid overload. Weighing at regular times gives better indication of weight changes.*

4. Assess for presence of dependent edema. *Dependent edema may indicate lack of kidney function.*

5. Observe voiding patterns to note deviations from normal.

6. Monitor urine specific gravity, serum electrolytes, BUN, and creatinine. *Rising levels may indicate decreased kidney function.*

7. Monitor hemodynamic status and vital signs. Notify doctor of any changes. *An increase from baseline may indicate fluid overload caused by lack of kidney function.*

8. Explain reasons for therapy and its intended effects to patient and family, to encourage patient to take an active role in health maintenance.

9. Allow for frequent rest periods to enable patient to conserve energy.

10. Refer patient to dietician for special diet for renal impairment to help patient avoid foods that place increased demands on kidneys.

11. Instruct patient to check with doctor before taking over-the-counter (OTC) medications. *OTC medications may be nephrotoxic.*

12. Administer low-dose dopamine, as ordered, to dilate renal arteries and encourage tissue perfusion. ‡

13. Provide patient and family with psychological support if renal failure proves to be chronic to encourage healthy adaptation.

Documentation

- Patient's expressions of concern over symptoms of decreased tissue perfusion
- Vital signs, intake and output, level of consciousness and other clinical findings
- Nursing interventions performed to maintain fluid balance and hemodynamic stability
- Patient's response to nursing interventions
- Patient's response to education
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Tissue perfusion alteration (gastrointestinal)

related to decreased cellular exchange

167b

Interventions and rationales (continued)

sis. *Such medications may contribute to decreased perfusion.*

17. Teach patient to rest after meals *to allow adequate blood circulation, thereby assuring oxygen supply for increased metabolic demands.*

Documentation

- Observations of physical findings
- Results of laboratory studies
- Intake and output
- Nursing interventions to treat altered tissue perfusion
- Patient's and significant other's response to teaching
- Effectiveness of nursing interventions
- Stool characteristics, including color, consistency, and presence of occult blood
- Evaluations for each expected outcome.

Care plan notes

Care plan notes

Interventions and rationales (continued)

- h. Teach family members and support personnel to assist, *thus reducing anxiety that results from noninvolvement and increasing chances for successful treatment.*
 - i. Respond to patient's call light promptly to *avoid delays in voiding routine.*
 - j. Choose patient's clothing to promote easy dressing and undressing. (For example, use Velcro fasteners and gowns instead of pajamas.) *This reduces patient's frustration with voiding routine.*
4. Schedule patient's fluid intake to encourage voiding at convenient times. Maintain adequate hydration up to 3,000 ml daily, unless contraindicated. *Optimum time interval between voiding is based on reasonable distention of bladder.* Limit fluid intake to 150 ml after dinner *to reduce need to void at night.*
5. Instruct patient and family or significant other on continence techniques to be used at

home, *to increase chances of successful bladder retraining.*

6. Encourage patient and family or significant other to share feelings related to incontinence. *This allows specific problems to be identified and resolved. Attentive listening conveys recognition and respect.*

7. Refer patient and family or significant other to psychiatric liaison nurse, visiting nurse's association, or support group *to provide access to additional community resources.*

Documentation

- Observations of incontinence and response to treatment regimen
- Interventions to provide supportive care and patient's response to supportive care
- Instructions given to patient and family or significant other; return demonstration of knowledge and skills needed to carry out continence management techniques

- Patient's expression of concern about incontinence and motivation to participate in self-care
- Evaluations for each expected outcome.

Care plan notes

Tissue perfusion alteration (gastrointestinal)

related to decreased cellular exchange

167a

Definition

Decrease in cellular nutrition and respiration caused by decreased capillary blood flow

Assessment

- Vital signs
- GI status, including abdominal distention; nausea and vomiting; usual bowel habits; change in bowel habits; stool characteristics (color, consistency); presence or absence of occult blood; history of GI problems, disease, or surgery; pain; inspection of abdomen; palpation for tenderness; auscultation of bowel sounds; abdominal girth
- Nutritional status, including dietary intake, change from normal diet, current weight, change from normal weight
- Laboratory studies, including complete blood count, serum electrolytes, liver profile
- Medications (especially those with vasoconstrictive properties)

Defining characteristics

- Absence of bowel sounds or change in their sound or frequency
- Abdominal pain associated with recently eaten meals
- Ascites or fluid wave
- Constipation
- Decrease in hematocrit and hemoglobin levels
- Diarrhea
- History of recent abdominal surgery or blunt abdominal trauma
- Increase in white blood count or sedimentation rate
- Nausea
- Presence of occult blood
- Recent weight loss or gain
- Vomiting

Associated medical diagnoses (selected)

Crohn's disease, duodenal ulcers, esophageal varices, GI cancer, GI hemorrhage, hepatic failure, hypovolemic liver failure, pancreatitis, paralytic ileus, small bowel obstruction, ulcerative colitis

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Intake and output remain within normal limits. (1)
- Normal bowel function returns. (4,7,8,9,10,11,12,13,16,17)
- Nausea and vomiting are eliminated. (7)
- Patient and significant other express understanding of need to modify dietary habits. (11,12,14,17)
- Patient discusses possible need to alter medication regimen with doctor. (16)
- Patient expresses understanding of benefits of regular exercise in maintaining routine bowel habits. (13)
- Abdominal pain subsides. (3,6)
- Laboratory values return to normal. (5,14)
- Vital signs remain stable. (2)
- Patient expresses understanding of need to check stools for occult blood. (15)

Interventions and rationales

1. Monitor intake and output every 4 hours to prevent hypovolemia, which may cause poor perfusion and subsequent ischemia.
2. Monitor patient's vital signs with tempera-

ture every 4 hours to detect possible hypovolemia and screen for infection.

3. Monitor for increased abdominal tenderness to detect early signs of increased ischemia.

4. Monitor bowel sounds and report changes. Changes in bowel sounds may signal impending obstruction or a return to normal bowel function.

5. Monitor complete blood count, serum electrolytes, and liver functions daily, as ordered, to detect ischemia caused by low hematocrit and hemoglobin, monitor for improvement in organ function, and screen for infection.

6. Administer prescribed pain medications sparingly. Many narcotics decrease gastric motility. If possible, use pain distraction techniques to provide pain relief with nonpharmacologic methods.

7. Implement nasogastric suction to eliminate nausea and vomiting, thereby reducing the risk of inflammation.

8. Establish bowel regimen to prevent constipation.

9. When appropriate, provide alternative methods of nutrition such as total parenteral nutri-

tion, to allow bowel rest and recovery and to prevent ischemic episodes after meals.

10. Start enteral feedings slowly and increase them gradually to allow recovering bowel to adapt to increased tissue demands.

11. Teach patient and significant other about dietary habits that may have contributed to poor perfusion to prevent future episodes of altered GI tissue perfusion.

12. Encourage patient to eat small, frequent meals to increase fluid intake and to eat more high-fiber foods, such as cruciferous vegetables and whole grains, to prevent constipation and potential obstruction.

13. Teach patient the importance of routine exercise. Routine exercise stimulates peristalsis.

14. Instruct patient to limit alcohol and fat intake to preserve adequate liver function.

15. Teach patient to check all stools for occult blood to monitor for blood loss which may indicate anemia.

16. Encourage patient to discuss with doctor the need to avoid medications with vasoconstrictive properties or which decrease peristal-

(continued)

† Numbers following outcomes refer to interventions.

Tissue perfusion alteration (specify)

related to hypovolemia

170a

Definition

Decrease in cellular nutrition and respiration because of decreased capillary blood flow

Assessment

- History of trauma, surgery, or condition resulting in fluid volume depletion
- Cardiovascular status, including blood pressure, capillary refill, central venous pressure, ECG, heart rate and rhythm, heart sounds, hemoglobin and hematocrit, jugular filling, peripheral pulses, tilt test
- Respiratory status, including breath sounds, respiratory rate and rhythm
- Renal status, including intake and output, urine specific gravity, weight
- Neurologic status, including level of consciousness, mental status, orientation
- Integumentary status, including color, moisture, temperature, turgor

Defining characteristics

- Absent or diminished pulses
- Anxiety
- Clinical evidence of blood and fluid volume depletion
- Cool, clammy skin
- Decreased blood pressure
- Decreased cardiac output
- Decreased central venous pressure
- Decreased urine output
- Increased pulse rate
- Increased systemic vascular resistance
- Persistent bleeding
- Poor skin turgor
- Respiratory difficulties
- Rhonchi, crackles

Associated medical diagnoses (selected)

Abruptio placentae; anemia; congestive heart failure; dehydration (loss of plasma volume); disseminated intravascular coagulation; GI bleeding; hemorrhage; hemothorax; hypovolemic shock; multisystem trauma; placenta previa; postoperative hypovolemia; pulmonary edema; renal failure; septic shock; spontaneous or therapeutic abortion; third-space fluid shifts in burns, bowel obstruction, and severe peritonitis; thrombosis

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient maintains hemodynamic stability: Pulse greater than _____, less than _____; systolic blood pressure greater than _____; central venous pressure greater than _____; mean arterial pressure greater than _____. (1,5,9)
- Patient maintains fluid balance; intake equals output. (3,5,9)
- Patient maintains urine specific gravity within normal parameters. (8)
- Patient maintains respiratory rate within ± 5 of baseline. (2,7)
- Patient maintains skin integrity. (10)
- Patient remains oriented to time, place, and person. (11)
- Crackles and rhonchi avoided. (5,7)
- Circulation improves. (4,5,6)
- Hemoglobin, hematocrit, white blood cell count, and coagulation studies remain within normal parameters. (12)
- Patient communicates understanding of medical regimen, diet, medications, and activity restrictions. (13)

Interventions and rationales

1. Monitor heart rate and rhythm, central venous pressure, and blood pressure every hour until stable, then every 2 hours; record and report any changes above or below figures noted in Expected Outcomes. Monitor skin color and temperature every 2 hours. *Decreased heart rate, decreased central venous pressure, and decreased blood pressure can indicate hypovolemia, which leads to increased tissue perfusion. Cool and blanching or mottled skin are clinical signs of decreased tissue perfusion.*
2. Monitor respiratory rate and depth every hour until stable, then every 2 to 4 hours. Record and report changes as noted in Expected Outcomes. *Increased respiratory rate is a compensatory mechanism in tissue hypoxia which may result from decreased tissue perfusion.*
3. Measure and record urine output every hour until greater than 30 ml/hour, then every 2 to 4 hours. *Poor renal perfusion results in decreased or no urine output. Urine output is a good indicator of tissue perfusion in absence of previous history of renal disease.*

4. Perform appropriate measures to treat underlying cause of hypovolemia. *Underlying cause must be treated to prevent continued or worsening hypovolemia. ‡*
5. Administer fluid or blood as ordered. Monitor for such adverse reactions as fluid overload or transfusion reactions. *Vigorous fluid or blood resuscitation can cause fluid overload, cardiac decompensation, or both. Transfusion reactions can occur during blood administration and may further compromise the patient's condition. ‡*
6. Initiate measures to help improve perfusion:
 - a. Keep warm, but do not overheat. *Warmth aids vasodilation, which improves tissue perfusion.*
 - b. Relieve anxiety and pain. *Anxiety and pain can cause a sympathetic reaction which results in vasoconstriction and decreased tissue perfusion.*
 - c. Elevate lower extremities, to increase arterial blood supply and improve tissue perfusion.
7. Perform pulmonary toilet as ordered; follow institutional policies. *Properly performed pul-*

(continued)

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Interventions and rationales (continued)

monary toilet helps prevent pulmonary edema, respiratory complications, and possible respiratory failure.

8. Test urine specific gravity every shift; record and report abnormalities. *Concentrated urine with an increased specific gravity is an indicator of hypovolemia.*

9. Weigh patient daily before breakfast; record weight. *Weighing patient daily helps predict total fluid status; weighing at regular times gives better indication of weight changes.*

10. Provide regular change of position; follow turning schedule; inspect skin every shift; record and report any potential areas of breakdown. *These measures avoid decreased tissue perfusion and risk of skin breakdown.*

11. Observe patient for confusion or disorientation. Reorient to reality frequently: call patient by name, tell patient your name, orient to surroundings (sounds, smells, sights).

Changes in level of consciousness may result

from decreased tissue perfusion. Reorientation helps patient recall person, place, and time and may also reduce fear and anxiety.

12. Monitor hemoglobin, hematocrit, white blood cell count, and coagulation studies. Frequency will depend on the severity of the patient's problem. *Monitoring helps establish blood replacement needs, fluid status, blood viscosity level, anticoagulation therapy parameters, and possible infection. ‡*

13. Educate patient in medical regimen (diet, medications, activity restrictions). *This allows patient to take an active role in health maintenance.*

Documentation

- Patient's expression of concern about hemodynamic status
- Observations of vital signs, intake and output, status of skin, and level of orientation
- Patient's response to nursing interventions

- Instructions about diet, monitoring, and medical regimen
- Evaluations for each expected outcome.

Care plan notes

‡ Indicates doctor-ordered instruction.

Care plan notes

Tissue perfusion alteration (venous)

related to reduced venous blood flow

171a

Definition

Decrease in cellular nutrition and respiration because of diminished venous blood flow

Assessment

- History of vascular problems or disease (self or family)
- Age
- Sex
- Medication history
- Integumentary status, including color, condition of nails, distribution of hair, lesions, temperature, texture
- Cardiovascular status, including capillary refill, clotting profile, Doppler studies, exercise test, heart rate and rhythm, pulses (brachial, femoral, pedal, peripheral, popliteal, posterior tibial, radial), serum cholesterol level, triglyceride levels, venogram or arteriogram
- Neurovascular status, including activity tolerance, mobility, sensation

- Nutritional status, including dietary patterns, weight
- Psychosocial status, including alcohol intake, family support, history of smoking, occupation, stressors

Defining characteristics

- Clinical evidence of interruption or reduction of venous blood flow
- Positive Homans' sign
- Prominence of superficial veins
- Skin: redness along course of vein, swelling around inflamed area, warm or hot to touch
- Tenderness and pain in affected extremity

Associated medical diagnoses (selected)

Abdominal tumors, chronic venous insufficiency, cirrhosis, hepatic failure, malignant ascites, oral contraceptive use, pregnancy, pulmonary embolus, sickle-cell crisis, thrombocytopenic purpura, thrombophlebitis (superficial or deep), varicose veins. Also any condition requiring prolonged bed rest, multiple venipunctures, or long-term I.V. therapy

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Embolization of thrombi avoided. (1,2,3,4,5,6,7)
- Inflammation lessened and venous blood flow improved. (6,7,8,9,10,11,12,13)
- Clotting studies remain within therapeutic range. (4,5)
- Patient explains reasons for measures being used to prevent pooling of blood in lower extremities. (7,8,9,10,11,12,13)
- Patient moves bowels without straining. (14)
- Patient demonstrates ability to perform skills needed for prescribed care regimen. (15)
- Patient identifies risk factors that exacerbate the problem. (15)

Interventions and rationales

1. Monitor and record temperature, pulse, respiration, and blood pressure at least every 4 hours. *Accurate monitoring of vital signs helps identify pulmonary embolus, which may increase respiratory rate, pulse rate, and blood pressure.*
2. Auscultate and record breath sounds every 4 hours. *Decreased, absent, or adventitious*

breath sounds may result from pulmonary embolus.

3. Observe for development of pulmonary emboli. Report immediately any increase in temperature, pulse, or respiratory rate; complaints of dyspnea, cough, hemoptysis; or the development of crackles or red, frothy sputum. Report any decrease in blood pressure.

Embolization of thrombi from deep veins (legs and pelvis) frequently causes pulmonary embolus.

4. Monitor clotting profile, as ordered. *This guides anticoagulant therapy and indicates potential for clot formation. ‡*

5. Administer anticoagulant therapy, monitor effectiveness, and observe for bleeding (epistaxis, bleeding gums, petechiae). *This reduces further thrombosis by preventing clot propagation.*

6. Measure and compare size of calves every 4 hours. *Venous pooling and stasis can cause fluid to move into interstitial space to cause edema.*

7. Apply antiembolism stockings or intermittent pneumatic compression stockings, as ordered.

Remove stockings for 1 hour every 8 hours or according to policy. *These may decrease venous stasis, but they can also cause edema from constriction. Monitor their use closely. ‡*

8. Apply moist heat to affected extremity, as ordered (may be contraindicated in chronic venous insufficiency.) *Moist heat may aid vasodilation, reduce vasospasm, and enhance venous return.*

9. Elevate affected extremity. Avoid using pillows under knees. *Do not use a knee gatch, and explain the reasons for not using it to the patient. Elevation aids venous return; pillows or knee gatch hinder venous return because they elevate knees above the feet.*

10. Instruct patient not to cross legs or lie in fetal position. Explain the importance of remembering not to cross legs. *Crossing legs constricts popliteal vessels, thus reducing venous return and promoting venous stasis.*

11. Increase patient's activity, as ordered. *This helps prevent venous pooling and stasis and promotes venous return. ‡*

12. Urge patient to elevate legs when sitting in a chair; be sure to support entire length of

(continued)

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Interventions and rationales (continued)

legs. *Elevating legs aids venous return. Supporting entire leg ensures blood flow.*

13. Encourage patient to walk. Discourage prolonged standing in one place. *Walking promotes venous blood flow by causing muscles to compress veins. Standing promotes venous stasis.*

14. Use stool softeners to avoid constipation and straining during bowel movement. *Valsalva's maneuver, used in straining during bowel movement, decreases venous blood return.*

15. Educate patient regarding the following:

- a. anticoagulant therapy and the importance of having blood work done as ordered; dietary precautions while on anticoagulant therapy (for example, minimizing green leafy vegetables if on oral agent); and the need to report bleeding gums and blood in urine, secretions, etc. *Leafy vegetables contain vitamin K, which inhibits anticoagulants*

such as coumadin. ‡

- b. use of antiembolism stockings or intermittent pneumatic compression stockings
- c. avoidance of crossing legs, wearing constrictive clothing, or standing in one place
- d. importance of protecting extremities from injury. *Education allows patient and family or significant other to take active role in health maintenance.*

Documentation

- Patient's expression of feelings about hospitalization and current situation
- Observations of physical findings
- Clotting profile
- Administration of anticoagulant therapy, including side effects
- Nursing interventions performed to promote circulation to lower extremities
- Patient's response to nursing interventions
- Patient's response to education
- Evaluations for each expected outcome.

Care plan notes

‡ Indicates doctor-ordered instruction.

Care plan notes

Definition

Accentuated risk of accidental tissue injury such as burns or fractures

Assessment

- Health history, including accidents, allergies, exposure to pollutants, falls, hyperthermia, hypothermia, poisoning, sensory or perceptual changes (auditory, gustatory, kinesthetic, olfactory, tactile, visual), seizures, trauma
- Circumstances of present situation that might lead to injury from surgery or from chemical, physical, or human agents
- Neurologic status, including level of consciousness, mental status, orientation
- Laboratory studies, including clotting factors, hemoglobin and hematocrit, platelet count, white blood cell count

Risk factors

- Bathtub lacks handgrip or anti-slip equipment
- High bed
- Inappropriate or broken call-for-aid mechanism for patient on bed rest
- Litter or liquid spills on floor
- Loose connections on invasive monitoring devices
- Patient contact with intense cold
- Patient sliding on coarse bed linens or struggling with bed restraints
- Patient smoking in bed or near oxygen
- Slippery floors (wet or highly waxed)
- Unlighted rooms or corridors
- Unsteady chairs

Associated medical diagnoses (selected)

Acute head injury, Alzheimer's disease, brain tumor, burns, cerebrovascular accident, drug overdose, fractures, hemophilia, Ménière's disease, multiple sclerosis, multisystem trauma, organic brain syndrome, Parkinson's disease, posttraumatic head injury, sedation or placement under general anesthesia, spinal cord injury

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient avoids injury. (1,2,3,4,5,6,7,8,9,10)
- Patient states understanding of safety precautions. (11)
- Patient uses assistive devices correctly (walker or cane, for example). (11)

Interventions and rationales

1. Observe, record, and report falls, seizures, and unsafe practices. *Accurate assessment promotes appropriate interventions; documentation ensures continuity of care.*
2. Monitor and record respiratory status. *Trauma increases respiratory rate; other respiratory effects depend on nature of trauma.*
3. Monitor and record neurologic status. *This assessment reflects all levels of nervous system.*
4. If a seizure occurs, remain with the patient, loosen restrictive clothing, and protect the patient from environmental hazards. Do not restrain the patient or pry the mouth open. Keep an oral airway at bedside. Maintain a patent airway. Turn the patient to the side after the seizure stops and suction if secretions occlude the airway. Record seizure characteristics

such as onset, duration, and body movements. Reorient the patient to surroundings and allow a rest period. *Remaining with the patient provides safety and information for the accurate documentation of the episode. Loosening the clothing and proper positioning may prevent further harm.*

5. Keep side rails up at all times *to protect the patient and provide a sense of security.*

6. Keep the bed in a low position except when providing direct care. *This minimizes the effects of a possible fall.*

7. Emphasize the importance of asking for help before getting up. *Patient may be weakened by illness or injury.*

8. Help the debilitated, weak, or unsteady patient get out of bed. Ensure that the floor is dry and that furniture and litter are out of the way. *This helps protect the patient from falling.*

9. When using soft restraints, do not secure them too tightly *to avoid giving the patient skin burns.* ‡

10. Use leather restraints when indicated and pad them well before applying. Release each extremity on a rotation basis every hour; check for skin burns. *Such restraints should*

be used only when other kinds are ineffective. ‡

11. Instruct the patient and family or significant other in safety practices, such as correct use of walker, crutches, or cane. *These enable the patient and family or significant other to take an active role in health care and maintain safe environment.*

Documentation

- Patient's statements that indicate potential for injury
- Physical findings
- Observations or knowledge of unsafe practices
- Interventions performed to prevent injury
- Patient's response to nursing interventions
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Definition

Accentuated risk of accidental tissue injury such as burns or fractures

Assessment

- Health history, including accidents, allergies, exposure to pollutants, falls, hyperthermia, hypothermia, poisoning, sensory or perceptual changes (auditory, gustatory, kinesthetic, olfactory, tactile, visual), seizures, trauma
- Circumstances of present situation that might lead to injury
- Neurologic status, including level of consciousness, mental status, orientation
- Laboratory studies, including albumin/globulin, clotting factors, hemoglobin and hematocrit, platelet count, white blood cell count

Risk factors

- Balancing difficulties
- Malnutrition
- Poor vision
- Reduced large or small muscle coordination
- Reduced tactile sensation
- Reduced temperature
- Weakness or fatigue

Associated medical diagnoses (selected)

Acute head injury, Alzheimer's disease, brain tumor, burns, cerebrovascular accident, hemophilia, Ménière's disease, multiple sclerosis, multisystem trauma, organic brain syndrome, osteoporosis, Parkinson's disease, posttraumatic head injury, sedation or placement under general anesthesia, seizure disorder, spinal cord injury, thrombocytopenic purpura

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient avoids injury. (1,2,3,4,5)
- Patient voices need for understanding safety precautions. (6,7)
- Patient uses safety devices correctly (walker or cane, for example). (6,7)

Interventions and rationales

1. Observe, record, and report falls, seizures, unsafe practices. *Accurate assessment promotes appropriate interventions; documentation ensures continuity of care.*
2. Monitor and record respiratory status. *Trauma increases respiratory rate; other respiratory effects depend on nature of trauma.*
3. Monitor and record neurologic status, to assess changes, and to report deteriorated status.
4. For seizures:
 - a. Place padded tongue blade at the bed-side to be used to prevent patient from biting tongue if seizure occurs. *Do not force tongue blade into patient's mouth. Unpadded blade may splinter and injure patient.*

- b. Keep side rails up *to protect patient and provide sense of security.*
 - c. Pad side rails.
 - d. Protect patient from further injury during the seizure.
 - e. Position patient on side *to prevent aspiration.*
- f. Record such seizure characteristics as onset, duration, and body movements. *Documenting seizure helps pinpoint involved area of brain and guides treatment.*
5. To prevent falls:
 - a. Keep bed rails up.
 - b. Maintain bed in a low position except when providing direct care.
 - c. Emphasize importance of asking for help before getting up. *Patient may be weakened by illness or injury.*
 - d. Provide help in ambulating, going to the bathroom, etc.
 - e. Anticipate times when falls occur (during the night, after administering a diuretic, while patient is sitting in a chair) and monitor patient closely *to prevent injuries.*

6. Instruct patient and family or significant other in use of such assistive devices as cane, walker, crutches, or wheelchair *to ensure their proper use and to provide patient with feeling of security.*
7. Provide patient and family or significant other with information about necessary safety precautions *to enable patient and family or significant other to take active role in health care and maintain safe environment.*

Documentation

- Patient's statements about the situation that indicate potential for injury
- Physical findings
- Record of falls, seizures, and unsafe practices
- Interventions that reduce risk of injury
- Patient's response to nursing interventions
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

Urinary elimination pattern alteration

related to obstruction

174a

Definition

Alteration or impairment of urinary function

Assessment

- History of urinary tract disease, trauma, surgery, or previous urethral infection
- Age
- Sex
- Vital signs
- Genitourinary status, including characteristics of urine, intravenous pyelogram, pain or discomfort, palpation of bladder, urinalysis, voiding patterns
- Fluid and electrolyte status, including blood urea nitrogen, creatinine, intake and output, mucous membranes (inspection), serum electrolytes, skin turgor, urine specific gravity
- Nutritional status, including appetite, constipation, dietary intake, elimination habits, present weight and change from normal, rectal examination

- Sexuality status, including capability, concerns, habits, sexual partner
- Psychosocial status, including coping skills, patient's perception of health problem, self-concept (body image), family or significant other, stressors (finances, job)

Defining characteristics

- Clinical evidence of urinary obstruction
- Dysuria
- Frequency
- Hematuria
- Hesitancy
- Incontinence
- Nocturia
- Retention
- Urgency

Associated medical diagnoses (selected)

Benign prostatic hypertrophy, bladder cancer, hydronephrosis, ileal bladder, ileal conduit, nephrolithotomy, pelvic neoplasm, prostate cancer, renal calculi, suprapubic or transurethral prostatectomy, urethral strictures, urinary diversion, urinary tract infection

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient maintains fluid balance; intake equals output. (1,2,3,6)
- Patient voices increased comfort. (2,5)
- Patient voices understanding of treatment. (4,5)
- Complications avoided or minimized. (1,2,6)
- Patient discusses impact of urologic disorder on self and family or significant other. (5,7,8,9)
- Patient and family or significant other demonstrate skill in managing urinary elimination problem. (5,9)

Interventions and rationales

1. Observe voiding pattern. Document urine color and characteristics, intake and output, and patient's daily weight. Report any changes. *Accurate intake and output measurements are essential for correct fluid replacement therapy. Urine characteristics help verify diagnosis.*
2. Administer appropriate care for the urologic condition; monitor progress (e.g., strain urine). Report favorable and adverse responses to treatment regimen. *Patient expects to receive adequate health care from qualified caregivers,*

and to be helped to understand the disease as well as treatment.

3. Observe bowel habits.
 - a. Check for constipation.
 - b. Check for fecal impaction; if present, disimpact and institute bowel regimen. *This promotes comfort and prevents loss of rectal muscle tone from prolonged distention.*
4. If surgery is to be performed, give appropriate preoperative and postoperative instructions and care. *Accurate information allows patient to deal with reality and builds trust in caregivers.*
5. Explain the reasons for therapy and the intended effects to patient and family or significant other, *to increase patient's understanding and build trust in caregivers.* If urinary diversion is planned, prepare patient for change in body appearance (instruct patient and family or significant other how to care for ostomy site postoperatively). *Physical need or changes in physical appearance may threaten health equilibrium. Appropriate information helps patient and family or significant other cope with problem.*

6. Provide supportive measures, as indicated.
 - a. Administer pain medication and monitor effectiveness. *Awareness that pain can be alleviated decreases pain intensity by relieving tension produced by anxiety. ‡*
 - b. Force fluids, as ordered, *to moisten mucous membranes and dilute chemical materials within the body. ‡*
 - c. Refer to dietitian for instructions on diet. *Dietary changes may decrease urinary infections. ‡*
 - d. Assist with general hygiene and comfort measures, as needed. *Cleanliness prevents bacterial growth and promotes comfort.*
 - e. Maintain patency of catheters, drainage bags, and other urinary elimination equipment *to avoid reflux and risk of infection, and ensure effectiveness of therapy.*
 - f. Provide meatal care according to hospital procedure *to promote cleanliness and comfort and reduce risk of infection.*
7. Encourage patient to ventilate feelings and concerns related to urologic problem. *Active listening conveys respect for patient; ventila-*

(continued)

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Urinary elimination pattern alteration related to obstruction

174b

Interventions and rationales (continued)

tion helps pinpoint patient's fears.

8. Refer patient and family or significant other to psychiatric liaison nurse, sex counselor, or support group, when appropriate. *These resources help patient gain knowledge of self and situation, reduce anxiety, and help promote personal growth. Community resources often provide support and care not available in other health agencies.*

9. Explain the urologic condition to patient and family or significant other, including instructions on preventive measures, if appropriate. Prepare for discharge according to individual needs. *Accurate health knowledge increases patient's ability to maintain health. Involving family or significant other assures patient that he will be cared for.*

Documentation

- Observations of urologic condition and response to treatment regimen
- Interventions to provide supportive care; patient's response to supportive care
- Instructions given to patient and family or significant other on the urologic problem; their response to instructions and demonstrated ability in managing urinary elimination
- Patient's expression of concern about the urologic problem and its impact on body image and life-style; patient's motivation to participate in self-care
- Evaluations for each expected outcome.

Care plan notes

Care plan notes

Urinary elimination pattern alteration

related to sensory or neuromuscular impairment

175a

Definition

Alteration or impairment of urinary function

Assessment

- History of urinary tract disease, trauma, surgery, or infection
- History of sensory or neuromuscular impairment
- Vital signs
- Genitourinary status, including characteristics of urine, cystometry, pain or discomfort, palpation of bladder, postcatheterization, presence and amount of residual urine; use of urinary assistive devices, urinalysis, voiding pattern
- Fluid and electrolyte status including blood urea nitrogen, creatinine, inspection of mucous membranes, intake and output, serum electrolytes, skin turgor, urine specific gravity
- Neuromuscular status, including degree of neuromuscular function present, motor ability to start and stop urinary stream, sensory abil-

ity to perceive bladder fullness

- Sexuality status, including capability, concerns, habits, sexual partner
- Psychosocial status, including coping skills, family or significant other, patient's perception of health problem, self-concept, stressors (finances, job)

Defining characteristics

- Clinical evidence of sensory or neuromuscular impairment of urinary tract
- Dysuria
- Frequency
- Hesitancy
- Incontinence
- Nocturia
- Retention
- Urgency

Associated medical diagnoses (selected)

Cerebrovascular accident, diabetes mellitus, hydronephrosis, multiple sclerosis, peripheral vascular disease, prolapsed lumbar disc, spinal cord tumor, spinal cord injury, spinal cord defect (myelomeningocele, spina bifida)

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient maintains fluid balance; intake equals output. (1,2,3)
- Patient voices increased comfort. (2,3,4)
- Complications avoided or minimized. (1,2,3,5,7)
- Patient and family or significant other demonstrate skill in managing urinary elimination problem. (5,6,7)
- Patient discusses impact of urologic disorder on self and family or significant other. (8,9)
- Patient and family or significant other identify resources to assist with care following discharge. (9)

Interventions and rationales

1. Monitor patient's neuromuscular status and voiding pattern; document and report intake and output. *Accurate intake and output measurements are essential for correct fluid replacement therapy. Data form basis for complete evaluation to diagnose causative factors.*
2. Provide appropriate care for the urologic condition; monitor progress. Report responses to treatment. *Patient expects to receive ade-*

quate health care from qualified caregivers, and to be helped to understand the disease as well as treatment. ‡

3. Assist with ordered bladder elimination procedure, as follows:

- a. *Bladder training*—Place patient on commode or toilet every 2 hours while awake and once during the night. Maintain regular fluid intake while patient is awake. Provide privacy. Teach patient how to perform Kegel exercises to strengthen sphincter control. *These measures aid adaptation to routine physiologic function. Women with good muscle tone may be able to improve levator muscle action significantly if Kegel exercises done routinely.*
- b. *Intermittent catheterization*—Catheterize patient using clean or sterile technique every _____ hours. Record amount voided spontaneously and amount obtained with catheterization (For example: 7 a.m., spontaneous void of 200 ml; catheter void of 150 ml). Record bladder balance every (day or week). *These measures promote normal voiding, pre-*

vent infection, and help maintain integrity of ureterovesical function. Catheterization schedule is based on flow sheet data and can provide a baseline chart.

$$\text{Bladder balance} = \frac{\text{Amount of residual urine}}{\text{Amount of voided urine}}$$

- c. *External catheter* (male patient)—Monitor patency. Apply condom catheter according to established policy. *Applying foam strip in spiral fashion increases adhesive surface and reduces risk of impairing circulation.* Avoid constriction. Observe skin condition of penis, and cleanse with soap and water at least twice a day. *These measures prevent infection, and ensure therapeutic effectiveness.*
- d. *Foley catheter*—Monitor patency. Keep tubing free of kinks; keep drainage bag below level of bladder, *to avoid urine reflux.* Cleanse urinary meatus according to established policy, and maintain closed drainage system, *to prevent skin irritation and bacteriuria.* Secure catheter to leg (female) or abdomen (male); avoid ten-

(continued)

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Interventions and rationales (continued)

- sion on sphincter. *Anchoring catheter avoids straining trigone muscle of bladder and prevents friction leading to inflammation.* ‡
- e. *Suprapubic catheter*—Monitor patency. Change dressing and cleanse catheter site according to policy. Keep tubing free of kinks; keep drainage bag below bladder level. Maintain closed drainage system. *Suprapubic drainage allows increased patient mobility and reduces risk of bladder infection.* ‡
4. Provide supportive measures:
- a. Administer pain medication and monitor effectiveness. *Awareness that pain can be alleviated decreases pain intensity by relieving tension produced by anxiety.* ‡
- b. Encourage fluid intake to as much as 3,000 ml every 24 hours (unless contraindicated), *to moisten mucous membranes*

- and dilute chemical materials within the body.*
- c. Provide privacy during toileting procedure. *This avoids inhibiting elimination.*
- d. Respond to patient's call light quickly, assign patient to bed next to bathroom, and have patient wear easily removed clothing, for example, gown rather than pajamas. *These measures reduce delay and impediments to voiding routine.*
5. Alert patient and family or significant other to signs and symptoms of full bladder: restlessness, abdominal discomfort, sweating, chills. *Adequate education increases patient's and family's ability to maintain health level, and to prevent patient from harming self.*
6. Instruct patient and family or significant other on catheterization techniques to be used at home; provide time for return demonstrations until procedure can be performed well. *Knowledge of procedures and rationales re-*

- duces anxiety and promotes comfort. Demonstrations may progress through several sessions until patient can perform independently.*
7. Instruct patient and family or significant other on signs and symptoms of autonomic dysreflexia (headache, cold sweat, nausea, elevated blood pressure) and on management of autonomic dysreflexia (check for kinked Foley catheter, catheterize, and elevate head of bed). Instruct patient and family or significant other to call doctor or hospital immediately if symptoms do not subside with initial treatment. *Autonomic dysreflexia is a pathologic reflex condition characterized by exaggerated autonomic responses to stimuli. It is a medical emergency.*
8. Encourage patient to ventilate feelings and concerns related to urologic problem. *Active listening conveys respect for patient; ventilation helps pinpoint patient's fears.*

(continued)

‡ Indicates doctor-ordered instruction.

Interventions and rationales (continued)

9. Refer patient and family or significant other to psychiatric liaison nurse, sex counselor, visiting nurses' society, or support group, when appropriate. *These resources help patient gain knowledge of self and situation, reduce anxiety, and help promote personal growth. Community resources often provide care and support not available in other health agencies.*

Documentation

- Observations of urologic condition and response to treatment regimen
 - Interventions to provide supportive care; patient's response to supportive care
 - Instructions given to patient and family or significant other; their understanding and demonstrated ability to manage urinary elimination
 - Patient's expression of concern about the urologic problem and impact on body image and life-style; patient's motivation to participate in self-care
 - Evaluations for each expected outcome.
-

Care plan notes

Urinary retention

related to obstruction or sensory
or neuromuscular impairment

176a

Definition

Incomplete emptying of bladder

Assessment

- History of sensory or neuromuscular impairment, prostate enlargement, surgery, urethral trauma or tumor, urinary tract disease
- Age
- Sex
- Vital signs
- Genitourinary status, including pain or discomfort, palpation of bladder, residual urine volume after voiding, urethral obstruction (prostate hypertrophy or masses, fecal impaction, masses, swelling), urinalysis, urine characteristics, voiding patterns
- Fluid and electrolyte status, including inspection of mucous membranes, intake and output, skin turgor, urine specific gravity, serum electrolytes, blood urea nitrogen, creatinine
- Medication history

- Neuromuscular status, including anal sphincter tone, motor ability to start and stop stream, neuromuscular function, sensory ability to perceive bladder fullness and voiding
- Sexuality status, including capability, concerns or partner's concerns, habits
- Psychosocial status, including coping skills; patient's or significant other's perception of problem, self-concept, stressors (finances, job)

Defining characteristics

- Bladder distention
- Dysuria
- Hesitancy
- High residual urine
- Loss of anal sphincter tone (with sensory or neuromuscular impairment)
- Nocturia
- Overflow incontinence (continuous dribbling)
- Sensation of bladder fullness (possible)
- Slow stream of urine
- Small, frequent voiding or no urine output

Associated medical diagnoses (selected)

Diabetic neuropathy, herniated intervertebral disk, nephrolithotomy, poliomyelitis, sacral nerve trauma or tumor, spinal cord injury (lower motor neuron), suprapubic or transurethral prostatectomy, surgical urinary retention, urethral obstruction (cancer of prostate, fecal impaction, fibroids, prostatic hypertrophy, stricture, surgical swelling), vitamin B₁₂ deficiency

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient maintains fluid balance; intake equals output. (1,6)
- Patient voices increased comfort. (4)
- Patient voices understanding of treatment. (9)
- Complications avoided or minimized. (1,2,5,7)
- Patient avoids bladder distention. (3)
- Patient and family or significant other demonstrate skill in managing urine retention. (9)
- Patient discusses impact of urologic disorder on self and family or significant other. (8,10)
- Patient and family or significant other identify resources to assist with care following discharge. (11)

Interventions and rationales

1. Monitor intake and output. Report if intake exceeds output. *Accurate intake and output measurements are essential for correct fluid replacement therapy.*
2. Monitor voiding pattern. *Data on time, place, amount, and patient's awareness of micturition are needed to establish pattern of incontinence.*

3. Assist with ordered bladder elimination procedure as follows:

- a. *Voiding technique*—Use Credé's or Valsalva's maneuver every 2 to 3 hours *to increase bladder pressure to pass urine.* Repeat until empty.
- b. *Intermittent catheterization*—Catheterize using clean or sterile technique every _____ hours. Record amount voided spontaneously and amount obtained with catheterization. *These measures promote normal voiding, prevent infection, and help maintain integrity of ureterovesical function. Catheterization schedule is based on flow sheet data and can provide a baseline chart. ‡*
- c. *Indwelling (Foley) catheter*—Monitor patency. Avoid kinks in tubing. Keep drainage bag below bladder level *to avoid urine reflux.* Perform catheter care according to established policy and maintain closed drainage system *to prevent skin irritation and bacteriuria.* Secure catheter to leg (female) or abdomen (male). Avoid tension on sphincter. *Anchoring catheter avoids straining trigone*

muscle of bladder and prevents friction leading to inflammation. ‡

- d. *Suprapubic catheter*—Change dressings according to established policy. Monitor patency. Avoid kinks in tubing. Keep drainage bag below bladder level. Maintain closed drainage system. *Suprapubic drainage allows increased patient mobility and reduces risk of bladder infection. ‡*
4. Administer pain medication, as ordered, and monitor effectiveness. *Awareness that pain can be alleviated decreases pain intensity by relieving tension produced by anxiety. ‡*
 5. For fecal impaction, disimpact and institute bowel regimen. *This promotes comfort and prevents loss of rectal muscle tone from prolonged distention.*
 6. Encourage high fluid intake (2,500 ml/day), unless contraindicated, *to moisten mucous membranes and dilute chemical materials within the body.* Limit fluid intake after 7 p.m. *to prevent nocturia.*
 7. Monitor therapeutic and adverse effects of prescribed medications *for early recognition*

(continued)

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Interventions and rationales (continued)

and treatment of drug reactions.

8. If surgery is to be performed, give appropriate preoperative and postoperative instructions and care to *increase patient's understanding and build trust in caregivers*. If urinary diversions are planned, prepare patient for change in body image. *Changes in physical appearance may threaten health equilibrium. Appropriate information helps patient and family or significant other cope with problem.*

9. Instruct patient and family or significant other on voiding techniques to be used at home. Provide for return demonstrations until procedure can be performed well. *Knowledge of procedures and rationales reduces anxiety and promotes comfort. Demonstrations may progress through several sessions until patient can perform independently.*

10. Encourage patient and family or significant other to share feelings and concerns related

to urologic problems. *Ventilation helps pinpoint patient's fears, and establishes environment of trust in which patient and family or significant other can begin to deal with the situation.*

11. Refer patient and family or significant other to psychiatric liaison nurse, enterostomal therapist, sex counselor, support group, or visiting nurse's association, when appropriate.

These resources help patient gain knowledge of self and situation, reduce anxiety, and help promote personal growth. Community resources often provide health care and support not available in other health agencies.

Documentation

- Observations of urologic condition and response to treatment regimen
- Interventions to provide supportive care; patient's response to supportive care
- Instructions given to patient and family or significant other on the urologic problem; their returned response and demonstrated ability to

manage urinary elimination

- Patient's expression of concern about the urologic problem and its impact on body image and life-style; patient's motivation to participate in self-care
- Evaluations for each expected outcome.

Care plan notes

Care plan notes

Definition

Inability to breathe adequately

Assessment

- Health history, including previous respiratory problems
- Respiratory status, including rate and depth of respiration, chest excursion and symmetry, presence of cyanosis, use of accessory muscles
- Effectiveness of cough in clearing secretions
- Suctioning demands, including frequency and tolerance
- Sputum characteristics, including appearance, consistency, color, odor
- Neuromuscular strength and endurance
- Mental and emotional status, including cognitive state and ability to follow directions
- Laboratory values, including arterial blood gas (ABG) levels (baseline and ongoing), complete blood count, serum electrolytes, co-

agulation studies, serum and sputum cultures, and sensitivity tests

- Vital signs
- Functional status, including ability to perform activities of daily living
- Related or concurrent events that may contribute to respiratory distress, such as bleeding, hypervolemia, hypovolemia, or sepsis

Defining characteristics

- Apprehension
- Decreased cooperation
- Decreased PaO_2
- Decreased SaO_2
- Decreased tidal volume
- Dyspnea
- Increased metabolic rate
- Increased PaCO_2
- Increased use of accessory muscles
- Respiratory muscle fatigue
- Tachycardia

Associated medical diagnoses (selected)

Acute streptococcal infection, adult respiratory distress syndrome, amyotrophic lateral sclerosis, chronic obstructive pulmonary disease, Guillain-Barré syndrome, hemothorax, hypervolemia, hypovolemia, multiple sclerosis, multisystem organ failure, Parkinson's disease, pneumonia, pneumothorax, sepsis, severe burns, tension pneumothorax, tracheal obstruction or stricture

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient's respiratory rate remains within ± 5 breaths per minute of baseline. (1,2,3)
- Patient's ABG levels are normal. (3,5,6,7,9,10,11)
- Patient indicates feeling comfortable and does not report pain, dyspnea, or fatigue. (3,5,6,7,8)
- Patient carries out activities of daily living with minimal supplemental oxygen. (7,9)
- Patient's breathing pattern returns to baseline. (3,6,7,10,11)
- As the patient's activity level increases, Pao₂ remains within normal limits. (9)
- After ventilator support is withdrawn, patient breathes spontaneously. (10)

Interventions and rationales

1. Monitor vital signs every 15 minutes to 1 hour *to detect tachypnea and tachycardia, early indicators of respiratory distress.*
2. Monitor the patient for nasal flaring, change in depth and pattern of breathing, use of accessory muscles, and cyanosis *to detect signs of severe respiratory distress.*
3. Monitor ABG levels and report deviations

promptly to determine the need for changes to the therapeutic regimen.

4. Monitor hemoglobin level and hematocrit. *Low hemoglobin level and hematocrit indicate decreased oxygen-carrying capacity of the blood.*

5. When initiating oxygen support, begin with the smallest concentration needed to make the patient comfortable. Monitor closely *to avoid oxygen toxicity.*

6. Place the patient in Fowler's position *to increase comfort and to promote adequate chest expansion and diaphragmatic excursion, and thereby decrease the work of breathing.*

7. Help the patient progress gradually from bed rest to increased activity *to improve patient's sense of well being.* Monitor vital signs and ABG levels closely. If respiratory status is compromised, return the patient to bed rest *to decrease the basal metabolic rate and lower oxygen demands.*

8. Explain all procedures to the patient. Describe specific sensations he may experience during each procedure *to decrease anxiety.*

9. Anticipate possible complications. Keep in mind that if the patient decompensates while

on a 100% FIO₂ nonrebreather mask, he may require endotracheal intubation. *Anticipating complications facilitates prompt intervention.*

10. If intubation is required, monitor the patient for spontaneous breathing and gradually wean him from the ventilator. *Progressive weaning helps the patient to adjust physiologically and emotionally to the increased work of breathing.*

11. Avoid respiratory depressants, such as narcotics, sedatives, and paralytics, *to facilitate the patient's recovery.*

Documentation

- Patient's reports of malaise, dyspnea, restlessness, chest pain, dizziness, lightheadedness
- Patient's response to nursing interventions
- Patient's response to initiation of oxygen therapy and progressive changes in therapy
- Laboratory data, including ABG levels
- Respiratory status (baseline and ongoing)
- Subtle personality changes
- Changes in lung sounds revealed by auscultation
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

Definition

Difficulty adjusting to lowered levels of ventilatory support

Assessment

- Health history, including previous respiratory problems
- Nutritional status
- Weight
- Neurologic status, including mental status, level of consciousness
- Emotional status, including signs of anxiety or stress
- Laboratory values, including arterial blood gas (ABG) levels (baseline and ongoing), serum electrolytes, complete blood count, blood and sputum culture, and sensitivity tests
- Weaning parameters and present ventilator settings
- Respiratory status, including respiratory rate, pattern, character, and depth; chest expansion and symmetry; sputum characteristics (color,

amount, odor, and consistency); cough effectiveness; presence of cyanosis in mucous membranes and nail beds; auscultation of lung sounds

- Need for suctioning, including frequency and patient's response
- Musculoskeletal status, including muscle mass, strength, and endurance level
- Cognitive state, including patient's ability to follow directions and readiness to learn
- Recent administration of potential respiratory-depressant medications, such as narcotics, sedatives, or neuromuscular blockers
- Vital signs
- Pulse oximetry readings (if available)

Defining characteristics

- Mild dysfunctional weaning response:
 - a. Breathing discomfort
 - b. Expression of increased need for oxygen
 - c. Fatigue
 - d. Increased concentration on breathing

- e. Queries about possible machine malfunction
- f. Restlessness
- g. Warmth
- Moderate dysfunctional weaning response:
 - a. Apprehension
 - b. Changes in skin color, paleness, slight cyanosis
 - c. Decreased air entry on auscultation
 - d. Hypervigilance to activities related to ventilator functioning
 - e. Inability to cooperate
 - f. Inability to respond to coaching
 - g. Increase in blood pressure (no more than 20 mm Hg above baseline)
 - h. Increase in heart rate (no more than 20 beats per minute above baseline).
 - i. Increase in respiratory rate (no more than 5 breaths per minute above baseline)
 - j. Slight accessory muscle use
 - k. "Wide-eyed" look

(continued)

Defining characteristics (continued)

- Severe dysfunctional weaning response:
 - a. Adventitious breath sounds
 - b. Agitation
 - c. Audible airway secretions
 - d. Cyanosis
 - e. Decreased level of consciousness
 - f. Deteriorating ABG levels
 - g. Full respiratory accessory muscle use
 - h. Increased blood pressure (more than 20 mm Hg above baseline)
 - i. Increased heart rate (more than 20 beats per minute above baseline)
 - j. Paradoxical abdominal breathing
 - k. Profuse diaphoresis
 - l. Shallow, gasping breath
 - m. Significant increase in respiratory rate
 - n. Uncoordinated breathing with the ventilator

Associated medical diagnoses (selected)

Adult respiratory distress syndrome, amyotrophic lateral sclerosis, burns, chronic obstructive pulmonary disease, metastatic disease, esophageal or tracheal anomalies, flail chest, morbid obesity, multiple trauma, myasthenia gravis, Parkinson's disease, pulmonary

edema, pulmonary effusions, pulmonary fibrosis, sepsis

Expected outcomes †

- Patient maintains respiratory rate within \pm 5 breaths per minute of baseline during weaning period. (3,5,7,9,10,11,12,13,15)
- ABG levels remain within acceptable limits (specify). (6)
- Patient's mental status and emotional state remain stable as ventilatory support is gradually withdrawn. (4,5,8,9,10,11,12)
- Patient expresses comfort with progressive ventilator changes. (1,2,3,4,5,6,7,8,9,10,11,12)
- Patient does not experience dyspnea, fatigue, or pain during progressive ventilator changes. (1,2,3,4,5,6,7,8,9,10,11,12)
- Adequate weaning parameters are maintained:
 - a. Tidal volume is 4 to 5 cc/kg
 - b. Negative inspiratory force is greater than or equal to -20 cm H₂O
 - c. Vital capacity is 10 to 15 cc/kg
 - d. Minute ventilation is 6 to 10 liters. (5,6,9,10,12)

- Patient's cough is effective in clearing secretions. (3,14)

Interventions and rationales

1. Monitor patient's vital signs every hour when changing ventilator settings. *Fever, tachycardia, tachypnea, and elevated blood pressure may indicate hypoxemia.* ‡
2. Auscultate for lung sounds every 2 hours and report deviations. *Adventitious sounds may precede respiratory failure.*
3. Place the patient in a comfortable position (preferably Fowler's) *to facilitate adequate chest expansion and drainage.*
4. Describe all weaning procedures to the patient. Explain that the patient may experience changes in breathing rate and pattern, increased difficulty breathing, and fatigue *to decrease anxiety.*
5. If patient is receiving intermittent mandatory ventilation (IMV), begin to decrease IMV by increments of two breaths per minute. This process may take place over a period of days to weeks. *Lowering the IMV encourages the pa-*

(continued)

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Interventions and rationales (continued)

tient to take his own breaths, and thereby exercise respiratory muscles. ‡

6. Monitor ABG levels with every ventilator change *to assess for adequate oxygenation and acid-based balance. ‡*

7. Include periods of rest between ventilator changes, especially at night, *to reduce tissue oxygen demand.*

8. If patient tolerates IMV of 2 to 4 breaths per minute, try pressure support ventilation (PSV). *PSV prolongs positive airway pressure during inspiration, allowing patient to regulate his own respiratory rate and tidal volume. ‡*

9. Once patient is breathing adequately without IMV, place him on continuous positive airway pressure (CPAP) of 5 cm H₂O *to prevent alveolar collapse. ‡*

10. When the patient tolerates continuous positive airway pressure, place him on T-piece (T-bar) of 30% to 50% FIO₂. *This allows the patient to breathe on his own, continue to re-*

ceive oxygen, and remain intubated in the event of respiratory compromise. ‡

11. Once the patient tolerates longer weaning periods, incorporate activities of daily living into daily routine *to increase muscular strength and endurance.*

12. When respiratory status, weaning parameters, and ABG levels are satisfactory, assist with removal of ventilator tubes, and keep oxygen mask on hand *to prevent respiratory compromise. ‡*

13. Assess patient for stridor, respiratory distress, or dysphonia and report these symptoms to doctor *to monitor for need for renewed ventilatory assistance.*

14. Perform chest physiotherapy and suctioning as needed *to maintain a patent airway.*

15. Monitor respiratory effects of medications closely and evaluate response to bronchodilators *to detect respiratory compromise. Avoid respiratory depressants.*

Documentation

- Patient's reports of malaise, anxiety, restlessness, breathlessness, unusual pain
- Patient's response to ventilator changes
- Subtle changes in patient's mental or emotional status
- Laboratory data, including ABG levels
- Patient's response to nursing interventions, including positioning, chest physiotherapy, and suctioning
- Patient's responses to medications, including narcotics and bronchodilators
- Respiratory rate, pattern, and depth, including changes from baseline
- Evaluations for each expected outcome.

‡ Indicates doctor-ordered instruction.

Care plan notes

Definition

Decreased ability to speak, understand, or use words appropriately

Assessment

- Neurologic status, including level of consciousness, orientation, cognition, memory (recent and remote), insight, and judgment
- Speech characteristics, including pattern (garbled, incomprehensible, difficulty forming words), language and vocabulary, level of comprehension and expression, ability to use other forms of communication (eye blinks, gestures, pictures, nods)
- Motor ability
- Circulatory status, including a history of cardiac and circulatory problems, pulse rate, blood pressure, arteriogram, electroencephalogram, and computed tomography scan
- Respiratory status, including dyspnea and use of accessory muscles

Defining characteristics

- Disorientation
- Dyspnea
- Flight of ideas
- Impaired articulation
- Inability or lack of desire to speak
- Inability to identify objects
- Inability to modulate speech
- Inability to name words
- Inability to speak in sentences
- Incessant verbalization
- Loose association of ideas
- Perseveration
- Phonation difficulties
- Reduced blood volume to the brain
- Stuttering or slurring

Associated medical diagnoses (selected)

Arteriosclerotic heart disease, arteriovenous malformation, atherosclerotic heart disease, berry aneurysm, brain tumor (benign or malignant), cerebrovascular accident, chronic obstructive pulmonary disease, shock, Wernicke's aphasia

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient's needs met by staff. (1,2,3,4,5,6,7,8,9,10)
- Patient and significant other express satisfaction with level of communication ability. (1,8,9)
- Patient maintains effective level of communication. (1,3,5,7,8,9,10)
- Patient answers direct questions correctly. (3,5,6,7,8)

Interventions and rationales

1. Observe patient closely for cues to needs and desires, such as gestures, pointing to objects, looking at items, and pantomime *because nonverbal cues give meaning to actions*. Do not continually respond to gestures if potential exists to improve speech, *thus encouraging such improvement*.
2. Monitor and record changes in speech pattern or level of orientation. *Changes may indicate improvement or deterioration of condition*.
3. Speak slowly and distinctly in a normal tone when addressing patient; stand where patient can see and hear you. *Modified speech promotes comprehension*.

4. Reorient patient to reality:
 - a. Call patient by name.
 - b. Tell patient your name.
 - c. Give patient background information (place, date, time).
 - d. Use TV or radio to augment orientation.
 - e. Use large calendars, reality orientation boards. *These measures develop orientation skills through repetition and recognition of the familiar*.
5. Use short, simple phrases and yes-or-no questions when patient's frustration level is high. *Reduced frustration promotes use of alternate communication techniques*.
6. Encourage attempts at communication and provide positive reinforcement *to aid comprehension*.
7. Allow ample time for response. Do not answer questions yourself if patient has ability to respond. *This improves patient's self-concept and reduces frustration*.
8. Repeat or rephrase questions if necessary to improve communication. Do not pretend to understand if you don't. *Reduced pressure improves comprehension*.
9. Remove distractions from environment dur-

ing attempts at communication. Use communication boards (including the alphabet and some common words and pictures) if appropriate. *Reduced distractions improve comprehension*.

10. Review diagnostic test results *to determine improvement or deterioration of disease process; adjust care plan accordingly*.

Documentation

- Patient's current level of communication, orientation, and satisfaction with communication efforts
- Observations of speech deficits, expressiveness and receptiveness, and ability to communicate
- Interventions carried out to promote effective communication
- Patient's observable response to nursing interventions
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

Definition

Decreased ability to speak, understand, or use words appropriately

Assessment

- History of respiratory, neurologic, or musculoskeletal disorder or surgery
- Respiratory status, including dyspnea, use of accessory muscles, and respiratory pattern
- Neurologic status, including mental status (level of consciousness, orientation, cognition, memory, insight, and judgment), speech (pattern, signing, and such communication aids as an artificial larynx, computer-assisted speech device, pen and pencil, slate, picture board, and alphabet board)
- Musculoskeletal status, including range of motion and manual dexterity

Defining characteristics

- Dyspnea
- Impaired articulation
- Inability or lack of desire to speak
- Inability to modulate speech
- Inability to speak in sentences
- Phonation difficulties
- Physical barriers to communication
- Slurring

Associated medical diagnoses (selected)

Cancer (head, neck, lung), facial fractures, fractured jaw, intubation with or without mechanical ventilation, laryngeal edema, laryngectomy, laryngitis, radical head or neck surgery (such as glossectomy), tracheostomy

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient communicates needs and desires without undue frustration. (1,2,3,4,5,6,7,8,9,10)
- Patient uses alternate means of communication. (2,4,6,7)
- Patient demonstrates correct use of adaptive equipment. (6,7,8)
- Patient states plans to use appropriate resources to maximize communication skills. (11)

Interventions and rationales

1. Maintain a consistent daily schedule of activities as much as possible. Observe patient closely for cues to needs and desires, such as gestures, pointing to or looking at objects, pantomime. *Nonverbal cues give meaning to actions.*
2. Obtain communication aids for patient's use, such as an alphabet board, slate, pen, paper, or picture board, *to provide alternative communication methods.*
3. Use short, simple phrases and yes-or-no questions *to avoid patient frustration and anxiety over communication.*

4. Encourage communication attempts; allow time to select or write words or pictures. *Reduced pressure improves interaction with others.*
5. Allow ample time for response; do not answer questions for patient. *This reduces the frustration of impaired communication.*
6. Consult with speech therapist to suggest such communication aids as an artificial larynx. Assist with use. *Appropriate early referral encourages use of communication aids.*
7. Demonstrate communication techniques to patient and significant others—such as gestures, sign language, and eye blink—*to develop alternative communication skills.*
8. Assist patient in energy-conserving techniques *to allow maximum breath for speech or use of communication aids.*
9. Use tracheostomy plug *to facilitate speech*, if tolerated by patient.
10. Provide patient with emergency call system (bell, call light, etc.) and respond to all calls immediately and in person. Place a sign over intercom to alert all staff members of need to respond quickly. *Prompt responses reduce patient's fear and anxiety.*

11. Encourage attendance at a laryngectomy club or other appropriate support groups. *This encourages patient's participation and reinforces positive attitude.*

Documentation

- Patient's feelings about inability to communicate
- Observations of patient's attempts to communicate, response to and ability to use alternate communication means, and level of frustration or fatigue
- Patient's response to nursing interventions
- Patient's preferences in daily care activities, such as when to shave or bathe, what kind of razor to use
- Evaluations for each expected outcome.

Care plan notes

† Numbers following outcomes refer to interventions.

Definition

Decreased ability to speak, understand, or use words appropriately

Assessment

- Neurologic status, including a history of neurologic disorders, mental status (orientation, level of consciousness, mood or behavior, knowledge and intelligence, vocabulary, and memory), speech (pattern, language, level of comprehension and expression, ability to use other forms of communication, such as gestures, pictures, and drawings)
- Psychological status, including a history of mental or psychiatric disorders, history of alcohol or psychotoxic drug use, stressors, phobias, coping strategies

Defining characteristics

- Difficulty with phonation
- Disorientation
- Flight of ideas
- Inability or lack of desire to speak
- Inability to identify objects
- Inability to modulate speech
- Inability to name words
- Inability to speak dominant language
- Inability to speak in sentences
- Incessant verbalization
- Loose association of ideas
- Stuttering or slurring

Associated medical diagnoses (selected)

Alcohol intoxication, alcohol withdrawal syndrome, Alzheimer's disease, bipolar disease (manic or depressive phase), drug overdose, organic brain syndrome, psychosis, or anxiety states

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient communicates needs and desires to family or significant other or staff. (1,4,5)
- Staff meets patient's needs. (1,2,3,4,5,6)
- Patient incurs no injury or harm. (1,2,7)
- Patient returns to baseline communication level. (1,4,5)
- Patient explains relationship of causative factors—such as alcohol—to inability to communicate effectively. (5,8)
- Patient begins to make plans to use self-help groups and other resources to improve psychological status. (8)

Interventions and rationales

1. Observe patient closely to anticipate needs; for example, restlessness may indicate need to urinate. *Nonverbal cues give meaning to actions.*
2. Maintain a quiet, nonthreatening environment to reduce anxiety. *Minimize anxiety by reducing environmental stimuli.*
3. Introduce yourself and explain procedures in simple terms. Encourage consistent use of the same terms for common objects or

needs. *Treating patient as normal may enhance responsiveness.*

4. Encourage communication attempts and allow patient time to say or write words in response. *Patient's response time may be slow, thoughts difficult to express.*

5. Assess patient's communication status daily and record. Match communication needs to interventions: for disorientation, use reality orientation techniques; for manic state, reduce environmental stimuli, talk softly and calmly; for alcohol withdrawal syndrome, reassure patient, do not reinforce presence of hallucinations, provide quiet environment; for a stutterer, use rhythm or song. *Communication status interventions must be tailored to the patient's situation.*

6. Determine patient's past interests and habits from family or significant other and discuss them with patient *to stimulate nonthreatening two-way conversation.*

7. Maintain a safe environment by using side rails, soft restraint or Posey vest, and other safety measures according to established policies, *to protect patient and reduce chance of injury.*

8. Refer patient to psychiatric liaison nurse, social services, community agencies, and such self-help groups as Alcoholics Anonymous. *Exploration and resolution of communication problems may require long-term follow-up.*

Documentation

- Patient's concern with level of communication
- Observations of patient's needs, communication attempts, orientation, and safety measures
- Interventions carried out to promote communication
- Contributing factors to poor communication and plans to improve psychological status
- Patient's response to nursing interventions
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

Definition

Presence of risk factors for self-directed or other-directed violence

Assessment

- Medical status
- Patient's life situation
- Recent stressors; coping behaviors
- History of chemical dependency (alcohol, drugs)
- History of suicide attempts (aggressive suicide attempts, lethality of suicide attempts, prior suicide attempts)
- Reaction of family or significant other
- History of violent behavior

Risk factors

Anger; depression (specifically active, aggressive acts); fear of self or others; history of assaults, weapons possession, or arrests; inability to verbalize feelings; increasing anxiety level; provocative behavior (argumentative, dissatisfied, hypersensitive, overreactive); vulnerable self-esteem

Associated medical diagnoses (selected)

Alcohol withdrawal, brain tumor, drug overdose, drug withdrawal, drug-induced psychosis

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient maintains self-control. (1,2,3,4,5,6,7,8,9,10,11,12)
- Patient reports feelings of losing control. (8,9,10,11,12)
- Patient expresses the need for help from individuals who are appropriately prepared to assist the patient. (13)

Interventions and rationales

1. Remove all objects that the patient could use to injure self or others *to ensure safe environment.*
2. Use short, declarative sentences when talking to patient. Speak in a firm tone of voice. *Calm, direct, and firm approach demonstrates caregiver's control over situation and reduces patient's own sense of lack of control over aggressive impulses.*
3. Call patient by name each time you approach *to demonstrate recognition and respect for patient as unique human being.*
4. Assign patient to a room close to the nurse's station to allow frequent observation. *This reassures patient of staff concern and ensures patient's safety.*
5. Do not leave patient alone in the bathroom or the shower *to avoid potential for injury.*
6. Take patient's feelings seriously. *Patient needs to feel that his feelings are valid and accepted without judgment.*
7. Allow distance between yourself and patient. Always keep hands visible to allay fears that you have medication or weapon. *Distance of 8 feet is considered nonthreatening and appropriate to maintain caregiver's safety.*
8. Explain in a firm, calm voice that patient is expected to remain in control. *Expecting patient to be in control increases possibility that patient will take control of behavior.*
9. Acknowledge that you are aware of patient's potentially violent behavior. *Doing so reduces patient's need to be defensive.*
10. Set limits on patient's behavior. Acknowledge understanding of patient's feelings and invite talking. *This reinforces expectation that patient act in a responsible, controlled manner. Encouraging talking provides support, reassurance, and positive reinforcement of desirable behaviors.*
11. Employ physical restraint only if "talking the patient down" is not possible and if appro-

priate assistance from security officers, mental health professionals, or other co-workers is immediately available. Follow institutional restraint policies. *Restraints are used to control patients who cannot control themselves, and to reassert staff control.*

12. Administer antianxiety or psychotropic drugs and monitor for effectiveness and side effects. *When used appropriately, medications often remove need for physical restraints. ‡*

13. Refer the patient for appropriate assistance from a nurse therapist, psychiatrist, alcohol rehabilitation counselor, drug counselor, or psychologist. *Use of specialized professionals or therapies, or both, may be needed to supplement interventions (e.g., psychotherapy, alcohol detoxification, or seclusion room.)*

Documentation

- Patient's statements indicative of escalating anxiety levels
- Observations about patient's verbal behavior
- Interventions to ensure safety and control
- Patient's response to nursing interventions
- Referrals
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Violence, high risk for: Self-directed

related to suicide attempt

183

Definition

Presence of risk factors for self-directed violence.

Assessment

- Age
- Sex
- Medical history
- Patient's life situation
- Recent stressors; coping behaviors
- Available support systems
- History of suicide attempts, including aggressiveness of suicide attempts, lethality of suicide attempts, prior suicide attempts
- History of substance abuse: type, effects on mental status
- Reaction of family or significant other
- Safety hazards
- Mental status, including abstract thinking, affect, content of thought, general information, insight, judgment, mood, orientation, recent and remote memory, thought processes

Risk factors

- Angry facial expression
- Aggressive suicidal behavior
- Direct or indirect statements indicating desire to kill oneself
- Fear of own impulsivity
- Feelings of helplessness, loneliness, hopelessness
- History of previous suicide attempts
- Possession of destructive implements (e.g., gun, knife, razor blade, scissors)
- Putting affairs in order—writing will, giving away possessions
- Real or threatened loss of loved one, memory, prestige, job, health
- Severe depression manifested by feelings of helplessness, loneliness, hopelessness
- Substance abuse or withdrawal
- Tense muscles
- Vulnerable self-esteem

Associated medical diagnoses (selected)

Any illness resulting in long-term disability or incapacity (terminal diseases, degenerative diseases, traumatic injury); dementia; major depressive disorder; personality disorders; schizophrenia; substance use disorders

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient won't harm self in hospital. (1,2)
- Patient recovers from suicidal episode. (3,4,5)
- Patient discusses feelings that precipitated suicide attempt. (6,7,8)
- Patient consults mental health professional. (9,10)
- Patient describes available resources for crisis prevention and management. (11)
- Patient voices improvement in self-worth. (6,7,8,9,10,11)

Interventions and rationales

1. Ask patient directly: "Have you thought about killing yourself?" If so, "What do you plan to do?" *Suicide risk increases if patient has a plan and is capable of acting upon it.*
2. Remove from patient's environment anything that could be used to inflict further self-injury (razor blades, belts, glass objects, pills). *This helps to ensure patient's safety.*
3. Make short-term contract with patient that he will not harm self during a specific time period. Continue negotiating until there is no evidence of suicidal ideation. *A contract gets*

subject out in the open, places some responsibility for safety on patient, and conveys acceptance of patient as worthwhile person.

4. Supervise administration of prescribed medications. *Medications may be appropriate alternative to verbal interventions. Nurse should be aware of drug actions and side-effects to assess patient's needs.* Ensure that patient does not hoard medications. ‡
5. Provide supervision (one-on-one observation when possible) for the patient based on hospital policy. *This ensures compliance with legal requirements to protect patient and reassures patient of staff concern.*

6. Use warm, caring, nonjudgmental manner to show unconditional positive regard.
7. Listen carefully to patient and don't challenge him. *This assures patient of undivided attention, concern, and support.*
8. Demonstrate understanding, but don't reinforce denial of current situation *because roots of suicidal feelings can be masked by denial. A trusting relationship helps patient gain insights into needs.*
9. Make appropriate referrals to mental health professionals to help patient work through

suicidal feelings and develop healthier alternatives.

10. Help patient set a goal for obtaining long-term psychiatric care. *Ambivalence about psychiatric care or refusal to consult with therapist marks suicidal patient's lack of insight and use of denial.*

11. Provide patient with telephone numbers and other information about crisis centers, hot lines, counselors, etc. *Alternatives may ease anxiety about perceived threat of long-term psychotherapy.*

Documentation

- Patient's comments about the suicide attempt and current feelings about it
- Observations of the patient's behavior
- Interventions performed to reduce or prevent self-destructive, violent behavior
- Patient's observable responses to interventions
- Evaluations for each expected outcome.

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Violence, high risk for: Self-directed or directed at others

related to organic brain dysfunction

184a

Definition

Presence of risk factors for self-directed or other-directed violence

Assessment

- History of head trauma or surgery
- Neurologic status, including cognition, computed tomography scan, electroencephalogram, insight and judgment, level of consciousness, memory (recent and remote), motor ability, orientation, sensory ability
- Psychosocial status, including verbalizations (voice quality and tone, speech content, threats), purposeful actions (pounding fists, throwing things), nonpurposeful actions (tremors, facial expressions), coping skills, drug or alcohol use, family or significant other, personality, socialization, stressors

Risk factors

- Anger
- Clinical evidence of organic brain dysfunction
- Disorientation to time, place, person
- Impairment of memory, judgment, and intellectual functioning
- Inability to voice feelings
- Increasing anxiety level
- Increased motor activity, pacing, excitement, irritability, agitation
- Overt and aggressive acts—goal-directed destruction of objects in environment
- Self-destructive behavior and active, aggressive, suicidal acts
- Suspicion of others, paranoid ideation, delusions, hallucinations

Associated medical diagnoses (selected)

Alzheimer's disease, anoxic encephalopathy, Korsakoff's psychosis, organic brain syndrome, senile dementia and psychosis, severe head injury

Turn card over to find EXPECTED OUTCOMES, INTERVENTIONS AND RATIONALES, and DOCUMENTATION.

Expected outcomes †

- Patient avoids injuring or harming self. (1,2,3,4,5,6,7,8,9,11)
- Patient avoids injuring or harming others. (1,2,3,4,5,6,7,8,9,11)
- Patient voices increased feelings of self-esteem. (7,8,11)
- Patient remains calm in a secure environment. (2,3,5,6,11)
- Patient maintains normal sleep-wake cycle. (9)
- Patient expresses feelings in nonviolent and nondestructive manner. (2,5)
- Family or significant other explains need for safety and protective measures. (10)
- Family or significant other expresses intent to use supportive services. (11)

Interventions and rationales

1. Provide close supervision and watch for early signs of agitation or increasing anxiety, such as increased motor activity and unreasonable requests or demands. *Early assessment helps defuse potentially explosive behavior by giving patient chance to find ac-*

ceptable ways to deal with aggressive tendencies.

2. Use a calm, unhurried approach when communicating, *to reduce patient's sense of lack of control.* Allow patient to express feelings in nonviolent ways, such as beating a pillow, participating in physical exercise, or working with clay. *Patient can successfully release tension when allowed to do so in presence of caregiver.* Put limits on aggressive and potentially violent behavior, *to reinforce expectation that patient act in responsible, controlled manner.*

3. Identify and remove from environment stimuli—persons, objects, or situations—that precipitate potentially destructive behavior. *Such stimuli may precipitate aggressive behavior in patients with cognitive and perceptual deficits.*

4. Remove from environment anything patient may use to inflict injury to self or others (belt, razor, glass objects, etc.), *to ensure patient's safety.*

5. Administer and monitor effectiveness of medications prescribed to control aggressive behavior and help patient remain calm. *Medication is least restrictive intervention and*

helps reduce patient anxiety and need for physical restraints. ‡

6. Restrain or seclude patient as necessary to prevent serious injury to self or others. Be sure to follow hospital policy for these procedures. *These measures serve when patient cannot control self in unrestricted environment. Restraint or seclusion require doctor's order and accurate documentation to ensure legal compliance and provide adequate clinical justification for their use. ‡*

7. Provide reality orientation if patient is confused and disoriented to allow for more effective staff-patient interaction. *Reorientation helps patient learn to separate and distinguish fantasy from reality.*

8. Establish a structured daily routine and help patient follow it. *This helps patient focus on reality, participate in positive goal-directed behaviors, and gradually develop self-control.*

9. Assess sleep pattern and establish a regular routine to combat sleep deprivation. *Sleep deprivation is characterized by cognitive, perceptual, behavioral, and performance changes (such as increased irritability, restlessness,*

(continued)

† Numbers following outcomes refer to interventions.

‡ Indicates doctor-ordered instruction.

Violence, high risk for: Self-directed or directed at others

related to organic brain dysfunction

184b

Interventions and rationales (continued)

confusion, disorientation, agitation, delusions, hallucinations, etc.).

10. Discuss reasons for safety and protective measures with family or significant other, *to reduce their anxiety and gain their understanding of need for restrictive interventions.*

11. Suggest referral to day-care center or sheltered workshop for continuation of psychosocial treatment. Arrange this through social services or home care program. *Assistance of specialized professionals may be needed to facilitate appropriate discharge planning and follow-up care.*

Documentation

- Patient's statement of intent to harm self or others
- Observations of behavior, precipitating factors, and methods used to control behavior
- Patient's responses to medical regimen and nursing interventions
- Family's or significant other's statement of understanding of protective safety measures (including seclusion or restraint) and need for follow-up
- Evaluations for each expected outcome.

Care plan notes

Care plan notes

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